

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be examined in 24 hours after death. Pages 4 and 5 are to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1
03334
M
X
1
0
MAY 1962
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03327
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY in 1b <u>20</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8513-CARROLL AVENUE</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20 SILVER SPRING</u> d. STREET ADDRESS <u>1 8513-CARROLL AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MIRIAM</u> First <u>AARONSON</u> Middle <u>AARONSON</u> Last		4. DATE OF DEATH <u>MARCH 10.</u> Month <u>1962</u> Day Year		9. AGE (In years last birthday) <u>40</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>BALTO., MD.</u>			
13. FATHER'S NAME <u>WOLF AARONSON</u>		14. MOTHER'S MAIDEN NAME <u>SARAH GRUSDA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HENRY AARONSON (Bro)</u> Address <u>906 NAVAHOE DR. SSPG MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>273X</u> DUE TO (b) <u>HYPOPLASTIC ANEMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>over 15 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>No</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 22</u> , 19 <u>62</u> to <u>MARCH 10</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>MARCH 10</u> , 19 <u>62</u> , and that death occurred at <u>10</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Israel Kessler</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/10/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>ISRAEL KESSLER, M.D.</u>		22d. ADDRESS <u>1801-16th ST. N.W.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3/11/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>B'NAI ISRAEL Cem</u>			
23d. LOCATION (City, town or county)		23e. (State)		23f. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Goodberg Funeral Home</u>		ADDRESS <u>4217-9th Ave</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>							

03837

CENTRAL BANK OF INDIA

03838

(M)



(M)

no money in

anyland

Montgomery

only

is minutes

gathered

Montgomery General Hospital

Route 1

Living in Alabama

Mar.

is

62

male white

March 17, 1962

Road Department Truck Driver

Lafayette, Va.

USA

Alabama

Hester, Alvin

762-20-0706

Hospital Records

State of Alabama
Department of Transportation
Birmingham, Alabama

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

74

I

2

VR A15 (4)
15M 9/60

1

2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03336
CERTIFICATE OF DEATH
03329

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 BETHESDA d. STREET ADDRESS 5822 LONE OAK DR. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE Middle R. Last ALLEN			4. DATE OF DEATH Month MARCH Day 10 Year 19 62				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 4/25/81		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CAMBRIDGE, MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NICHOLS G. HENRY		14. MOTHER'S MAIDEN NAME CORNELIA RADCLIFFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Address DAUGHTER, MRS. BETTY MOSSBURG			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary artery thrombosis 420.1 DUE TO (b) Myocardial infarct Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) Coronary atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes INTERVAL BETWEEN ONSET AND DEATH No to full day 12 days years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 19 57 to March 9, 19 62 ; that (I) (we) last saw the deceased alive on March 9, 19 62 , and that death occurred at 6:30 AM , from the causes and on the date stated above.					
22a. SIGNATURE Allen J. O'Neill M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Allen J. O'Neill, MD		22d. ADDRESS 8601 Old Georgetown Rd Bethesda MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/13/62		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery			
23d. LOCATION (City, town or county) Rockville, Maryland		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS		25a. REC'D BY REGISTRAR MAR 14 '62			
25b. REGISTRAR'S SIGNATURE C. A. Pumphrey		25c. DATE					

00000

00000



00 10

10/10

Yes



Robert A. Thompson, Bethesda, Maryland
3/15/52
Bethesda, Maryland

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03337

03330

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Silver Spring					
c. LENGTH OF STAY IN 1b 9 years				d. STREET ADDRESS 10,205 Douglas Avenue					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,205 Douglas Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Annie Middle R. Last Alsop				4. DATE OF DEATH Month March Day 9 Year 19 62					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 2, 1885			
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Washington, D. C.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME William Barrett				14. MOTHER'S MAIDEN NAME Emile Gale					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None				16. SOCIAL SECURITY NO. 58 579-30-2198					
17. INFORMANT Carl E. Alsop				Address 10205 Douglas Ave, S.S., Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 1								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 10,110 Georgia Ave, Silver Spring, Md.				(County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 23, 1961 to March 9, 1962 , that (I) (we) last saw the deceased alive on March 9, 1962 , and that death occurred at 11:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE Edward J. Richards				22b. DATE SIGNED 3-9-62					
22c. PHYSICIAN'S NAME (Type) Edward J. Richards				22d. ADDRESS 10,110 Georgia Ave, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-13-62		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			
23d. LOCATION (City, town, or county) Prince George's Co., Maryland				(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR MAR 13 '62					
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas									

M

I

MEDICAL CERTIFICATION

TO HOSPITAL
TO FUNERAL DIRECTOR:
TO HEALTH DEPT.
TO HOSPITAL
TO FUNERAL DIRECTOR:
TO HEALTH DEPT.

24 hours after death, page 4 retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03338											
CERTIFICATE OF DEATH											
Item 7 Film G509 3/19/62 iwk											
03331											
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN lb 4 1/2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN						2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEVY CHASE d. STREET ADDRESS 4860 Chevy Chase Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HARRY Dorsey AMISS First Middle Last						4. DATE OF DEATH March 11 19 62 Month Day Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/21/1885 yrs. Months Days Hours Min.		9. AGE (In years last birthday) 77 IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Salesman-ret						10b. KIND OF BUSINESS OR INDUSTRY Meat products		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edmund L. Amiss						14. MOTHER'S MAIDEN NAME Angeline Greene					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. 577-07-4520		17. INFORMANT Address Helen F. Amiss-wife-same 2d			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cardiac Failure 527.1 DUE TO Arricular Fibrillation Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Frequent Pneumonias DUE TO Emphysema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 5 hours Many years " " " "											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 1932 to May 10, 1962, that (I) (we) last saw the deceased alive on May 10, 1962 and that death occurred at 5:30 AM from the causes and on the date stated above.											
22a. SIGNATURE Bradley D. Hodgkins M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) bradley D. Hodgkins						22d. ADDRESS 4443 Bradley Lane Chevy Chase Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/14/62		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION (City, town or county) Gaithersburg, Maryland (State)					
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
VR A15 (A) 15M 9/60						DATE MAR 14 '62		C. L. S. K. H. S.			

00000

00000

M

Admiral A. H. Miles
1917-1920
Admiral A. H. Miles
1917-1920

Robert A. Bingham, Secretary, Maryland

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03339

CERTIFICATE OF DEATH

03332

Item 23b Film G310 4/2/62 mh

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE South Carolina b. COUNTY Folly Beach c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 105 W. Erie Avenue d. STREET ADDRESS 105 W. Erie Avenue			
3. NAME OF DECEASED (Type or print) Louis Martin Anderson Jr.				4. DATE OF DEATH Month Day Year March 20, 19 62			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 12, 1961	
9. AGE (In years last birthday) 6		10. IF UNDER 1 YEAR Months Days Hours Min. 6 9		11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Martin Anderson Sr.				14. MOTHER'S MAIDEN NAME Carol Ann Cornelius			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. FATHER: Louis M. Anderson Sr., Same as #2			
17. INFORMANT FATHER: Louis M. Anderson Sr., Same as #2				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO (b) Brain Damage DUE TO (c) Hypoglycemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from February 10, 1962 to March 20, 1962 , that it (we) last saw the deceased alive on March 20, 1962 , and that death occurred at 6:50 PM from the causes and on the date stated above.							
22a. SIGNATURE Frederic A. Schulaner M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 21, 1962	
22c. PHYSICIAN'S NAME (Type) Frederic A. Schulaner LT MC USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 23, 1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumporey Funeral Home, 1557 Wisc. Ave.,				25a. REC'D BY REGISTRAR MAR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

(M)

03832

03832

Montgomery

Booth Carolina

Bellevue (Rural)

18 days

Rolls Beach

U. S. Naval Hospital

105 W. Erie Avenue

Isola Martin Anderson Jr.

March 20,

Commission

September 12, 1901

Child

South Carolina

Isola Martin Anderson Jr.

Carol Ann Correll

FATHER: Louis M. Anderson Jr., Same as 42

Isola Martin Anderson Jr.
born 12 days
March 20, 1901

NY

Mar. 20, 02

February 10, 02

March 20, 02

Isola Martin Anderson Jr.

March 21, 02

Frederick A. Schlander Jr. U. S. Naval Hospital, Washington, D.C.

Williamson National

Bureau

Washington, D.C.

MARCH 20

CHAS. L. WALKER

Robert A. Tomlinson, Federal Home, 1001 King Ave.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03333

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 16 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 29 Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 610 Pershing Drive				d. STREET ADDRESS 1 610 Pershing Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George (nmi) Argerake				4. DATE OF DEATH Month March Day 6 Year 19 62			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1897		9. AGE (in years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 64 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gro. Clerk		10b. KIND OF BUSINESS OR INDUSTRY N&B Delicatessen		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Argerake				14. MOTHER'S MAIDEN NAME Maria Chagaroulis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. yes		17. INFORMANT Address Patricia J. Argerake 610 Pershing Dr, S.S., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peracardial Tamponade DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rup. of heart DUE TO (c) Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH sudden 7 to 10 das.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident					
20c. TIME OF INJURY Hour 5:00 p.m. Month Sept. Day 1960		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Wash. D.C.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED March 7, 1962			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-8-62		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or country) (State) Washington, D.C.	
23. FUNERAL DIRECTOR Raymond A. Ziska				24a. REC'D BY REGISTRAR 8434 Georgia Ave.		24b. REGISTRAR'S SIGNATURE Warner E. Pumphrey, Inc. Silver Spring, Maryland	

003388

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		35		Male		White		1945		New York	
Occupation		Cause of Death		Manner of Death		Medical History		Previous Illnesses		Post-mortem Examination	
Teacher		Heart Disease		Natural		None		None		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Medical Officer		Signature of Health Officer		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Examination		Time of Examination		Place of Examination		Name of Hospital		Name of Doctor		Name of Nurse	
1945		10:00 AM		New York		St. John's		Dr. Smith		Mrs. Jones	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03341

Items 1 & 2 Film G308

CERTIFICATE OF DEATH

3/12/62 iwk

03334

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>32</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Manor Club Estates</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>Carrolton & Norbeck</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charlotte</u> First <u>Louise</u> Middle <u>Ballard</u> Last 4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1962</u>			
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 19, 1888</u> 9. AGE (In years last birthday) <u>73</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George H. Langhenry</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Burton M. Langhenry</u> Address <u>Md. Manor Club Estates, Rockville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> DUE TO <u>Carcinoma of Cecum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-29</u> , 19 <u>62</u> to <u>3-3</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2-28</u> , 19 <u>62</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>C. Roger Kurtz</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz, M.D.</u>		22b. DATE SIGNED <u>3-3-62</u> 22d. ADDRESS <u>3701 Connecticut Ave NW Wash 8, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-6-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Bladensburg Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Ca. Ave., N.W., Wash., D.C.</u> 25a. REC'D BY REGISTRAR <u>8 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Clifford L. Thomas</u>	

0330

1920



03342

CERTIFICATE OF DEATH

Reg. Dist. No.

03335

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSP.		d. STREET ADDRESS 3908 BALTIMORE ST.	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM L. BARKER		4. DATE OF DEATH Month Day Year March 11 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-76
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Millwright	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ZACKWEIL MORGAN BARKER		14. MOTHER'S MAIDEN NAME MARY ELLEN RIGGS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 235-12-7287	
17. INFORMANT DAUGHTER MRS MILYRED HARMAN S/A		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia (c) Pyelitis and Prostatitis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 4 days 4 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC 3/11 , 19 55 , to 3/11 , 19 62 , that I last saw the deceased alive on 3/11 , 19 62 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank Y. Jiggers Jr. M.D.		ADDRESS (Street, city or town, state) 5707 W. Connel Ave DATE SIGNED 3/11/62	
PHYSICIAN'S NAME (Type) FRANK Y. JIGGERS JR.		Chevy Chase 15, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-13-62	22c. NAME OF CEMETERY OR CREMATORY Colesville Cemetery	22d. LOCATION (City, town, or county) (State) Colesville Montgomery Co, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		ADDRESS 8434 Georgia Ave	
24a. REC'D BY REGISTRAR MAR 14 '62		24b. REGISTRAR'S SIGNATURE W. E. Pumphrey	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03343

03336

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>12 hrs. 25 mins.</u>		d. STREET ADDRESS <u>1536-Independence Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Henry Barnes</u>		4. DATE OF DEATH <u>March 31</u> 19 <u>62</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/18/17</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frances Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Frances Mack</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Chloe Barnes</u> Address <u>Same As Above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>STATUS</u>		ASTHMATICUS	
Conditions, if any, which gave rise to immediate cause (b) <u>ADRENAL</u>		INSUFFICIENCY	
e), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/31/62</u> 19 <u>62</u> , to <u>3/31/62</u> 19 <u>62</u> , that (I) <u>was</u> last saw the deceased alive on <u>3/31/62</u> , and that death occurred at <u>6:45</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>John E. Everett</u> M.D.		22b. DATE SIGNED <u>4/1/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		22d. ADDRESS <u>9400 Conn Ave Kensington Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/4/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Ernest Jarvis Co., Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 5 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

100000

000000

(M)

Handwritten text, likely a letter or document, written in cursive script. The text is mostly illegible due to fading and bleed-through from the reverse side.

STATES
GENERAL

Handwritten text, likely a signature or name, written in cursive script. The text is mostly illegible due to fading and bleed-through from the reverse side.

Handwritten text, likely a signature or name, written in cursive script. The text is mostly illegible due to fading and bleed-through from the reverse side.

Handwritten text, likely a signature or name, written in cursive script. The text is mostly illegible due to fading and bleed-through from the reverse side.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03344

03337

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14511 Colesville Rd. Marilea Nursing Home				d. STREET ADDRESS 901 Snider Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alpha L. Middle Beck Last				4. DATE OF DEATH Month March Day 26 Year 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/29/87	
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Elsworth M. Eastwood		14. MOTHER'S MAIDEN NAME Dena F. Huffman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-48-8280		17. INFORMANT Edward R. Beck same as #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Acute myocardial infarction DUE TO (b) Chronic myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 3 days 3 mo.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 2, 1962 to March 26, 1962 , that (I) (we) last saw the deceased alive on March 26, 1962 and that death occurred at 4 P.M. from the causes and on the date stated above.							
22a. SIGNATURE John S. Rogers, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 26, 1962	
22c. PHYSICIAN'S NAME (Type) John S. Rogers				22d. ADDRESS 1919 Seminary Rd. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3/29/62		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company				24a. REC'D BY REGISTRAR 2901 14th St. N.W.		25b. REGISTRAR'S SIGNATURE Clifford L. Hines	
				DATE MAR 28 '62			

03337

CERTIFICATE OF DEATH

1944

(M)

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

101 Street, New York

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03345

03338

1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b 60 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Flintstone		d. STREET ADDRESS Route #2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter Wayne Bender				4. DATE OF DEATH Month March Day 26 Year 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 October 1938		9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months 23 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter L. Bender				14. MOTHER'S MAIDEN NAME Eva Wilson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ^{Address} The Medical Record, The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 years						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Hour e.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that 10 (this hospital) attended the deceased from Jan. 25, 1962 , to March 26, 1962 , that 11x (we) last saw the deceased alive on March 26, 1962 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Michael Field				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> March 26, 1962		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Michael Field, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/62		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) Cumberland, Maryland (State) _____	
24 FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR MAR 28 '62		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

MEDICAL CERTIFICATION

00000

00000

(M)

Mr. J. C. ...

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

...

Richard ...

... ..

... ..

... ..

John J. ...

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03346

CERTIFICATE OF DEATH

Item 8 Film G308 3/9/62 mh

03339

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>32 Silver Spring</u> d. STREET ADDRESS <u>309 Belton Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u>	4. DATE OF DEATH <u>3</u> <u>5</u> <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u> <u>12-17-77</u> <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W. CORSETIER RE RETIRED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>JEROME LEVINSON</u>		14. MOTHER'S MAIDEN NAME <u>DEBORAH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>102-03-4268</u>	
17. INFORMANT <u>GEORGE BLOOM</u>		Address <u>309 BELTON RD. SSMD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 4 4 3X DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Hyper Tensive Heart Disease</u> (c) <u>Gastrointestinal Bleeding & Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 Hours</u> <u>Un Known</u> <u>Un Known</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 4</u> , 19 <u>62</u> to <u>March 5</u> , 19 <u>62</u> that (I) <u>was</u> last saw the deceased alive on <u>March 5</u> , 19 <u>62</u> , and that death occurred at <u>3:15</u> P.M. from the causes and on the date stated above.			
22e. SIGNATURE <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>3-5-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>STUART L. NELSON, M.D.</u>		22d. ADDRESS <u>7600 CARROLL AVE. TAK. PK. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MARCH 6, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>AT. HEBRON CEMETARY</u>		23d. LOCATION (City, town or county) (State) <u>FLUSHING L.I. NY</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Dugan & Sons</u>		25a. REC'D BY REGISTRAR <u>MAR 7 '62</u>	
ADDRESS <u>3501-14th NW</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



03332

03332

Washington State
Department of
Social Services
Division of
Child Welfare
Seattle, Washington
February 14, 1964
To: [illegible]
From: [illegible]
Subject: [illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal letter or report.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03347
03340
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in lb 5 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Resmor Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda West Point d. STREET ADDRESS 15141 Grosvenor/Katara 833 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY ELIZABETH BESWICK		4. DATE OF DEATH Month 3 Day 26 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1881
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 8 Days 3	11. IF UNDER 24 HRS. Hours 8 Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 1	
11. BIRTHPLACE (County & State, or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Richard Webb		14. MOTHER'S MAIDEN NAME Mary Elizabeth Dutton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT HERBERT G. BESWICK		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE DUE TO HEART FAILURE (? INFARCTION) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ARTERIO SCLEROTIC HEART DISEASE DUE TO 1- DAY 20+ YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATOID ARTHRITIS. EPILEPSY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/22/57 , 19 57 , to 3/26/62 , 19 62 , that (I) (we) last saw the deceased alive on 3/26/62 , 19 62 , and that death occurred at 8:15 M. from the causes and on the date stated above.			
22a. SIGNATURE Charles J. Savarese M.D.		22b. DATE 3/26/62	
22c. PHYSICIAN'S NAME (Type) CHARLES J. SAVARESE, MD		22d. ADDRESS 4890 BATTERY LA. BETHESDA, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/62	
23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City, town or county) (State) Hopewell, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 30 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

03340

03340

WILLIAMSON, MARY ELIZABETH

Female W. 11-18-1901

Housewife

WILLIAMSON, MARY ELIZABETH

Female W. 11-18-1901

Housewife

WILLIAMSON, MARY ELIZABETH

Female W. 11-18-1901

Housewife

WILLIAMSON, MARY ELIZABETH

Female W. 11-18-1901

Housewife

WILLIAMSON, MARY ELIZABETH

Female W. 11-18-1901

Housewife

WILLIAMSON, MARY ELIZABETH

Female W. 11-18-1901

Housewife

TO HOSPITAL OR A DURING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

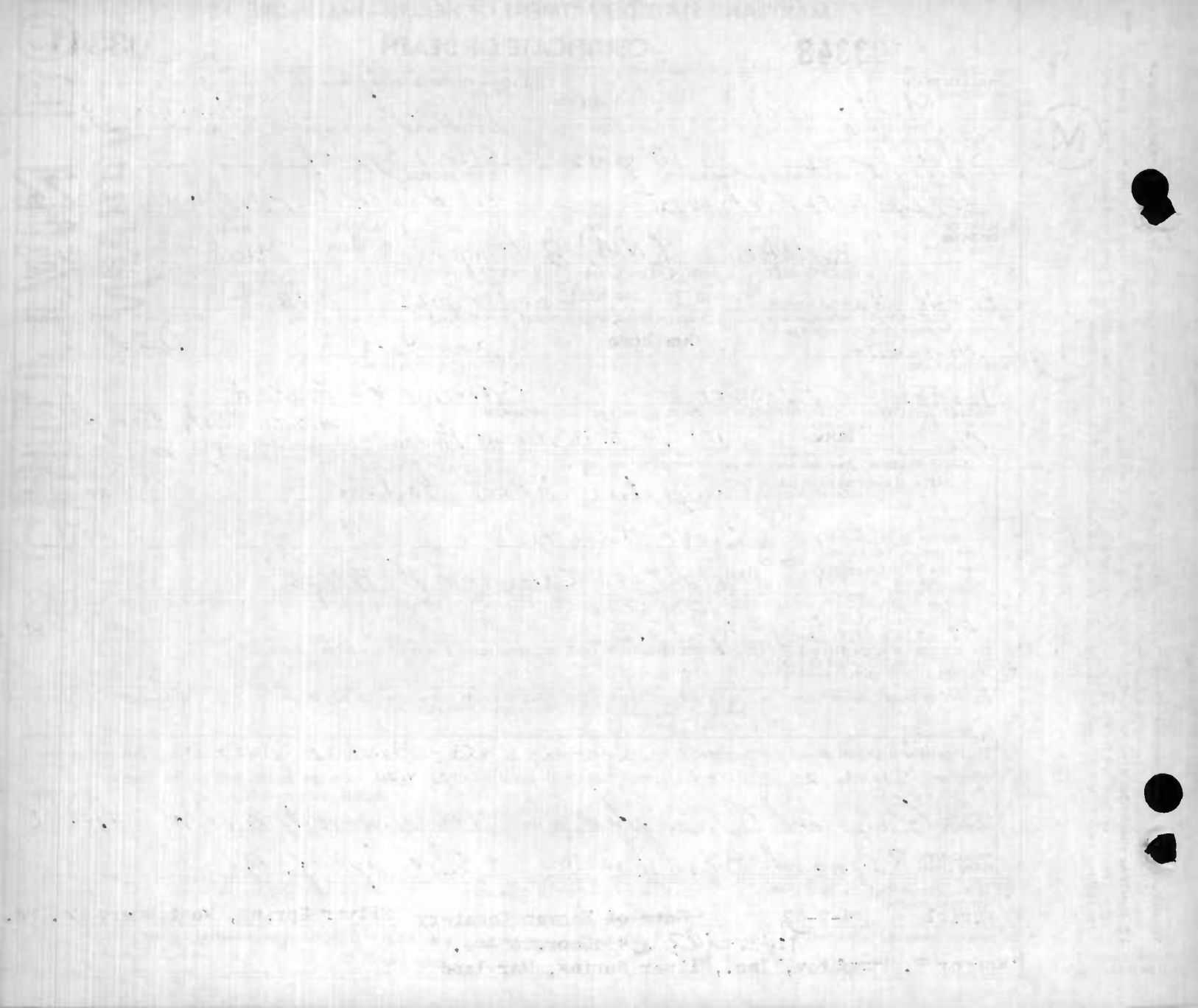
03348

CERTIFICATE OF DEATH

Reg. Dist. No. 03341

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>22 Silver Spring</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>407 University Blvd, West</i>				d. STREET ADDRESS <i>407 University Blvd, West</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <i>Kathleen</i> Middle <i>(NMI)</i> Last <i>Bettinger</i>				4. DATE OF DEATH Month <i>March</i> Day <i>30</i> Year <i>1962</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Caucasian</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 11, 1923</i>			
9. AGE (In years last birthday) <i>38</i> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>									
13. FATHER'S NAME <i>Joseph Bloomer</i>				14. MOTHER'S MAIDEN NAME <i>Catherine V. Finnan</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <i>No</i> <i>None</i>				16. SOCIAL SECURITY NO. <i>101 14 5048</i>					
17. INFORMANT <i>Catherine Finnan</i>				Address <i>407 University Blvd W Silver Spring, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO (b) <i>Liver failure</i> DUE TO (c) <i>Metastatic Carcinoma of Breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Rt. mastectomy, April 1960.</i>								INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>1 mo</i> <i>3 mo</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from <i>January, 1953</i> , to <i>March 30, 1962</i> , that I last saw the deceased alive on <i>March 29, 1962</i> , and that death occurred at <i>12:40 AM</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Raymond Bradshaw, Jr.</i> M.D.				ADDRESS (Street, city or town, state) <i>345 University Blvd W. Silver Spring, Md.</i>					
DATE SIGNED <i>3/30/62</i>									
PHYSICIAN'S NAME (Type) <i>Raymond Bradshaw, Jr.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>4-2-62</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>			
22d. LOCATION (City, town, or county) <i>Silver Spring, Montgomery Co. Md.</i>				(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc., Silver Spring, Maryland</i>				24a. REC'D BY REGISTRAR <i>APR 2 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1

0

2

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03349

03342

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u>		d. STREET ADDRESS <u>203 Croyden Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>203 Croyden Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Thompson Blanks Jr.</u>				4. DATE OF DEATH Month <u>mar</u> Day <u>29</u> Year <u>1962</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7-6-08</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>T.V. Repair</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lynchburg, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Robert T. Banks</u>				14. MOTHER'S MARRIED NAME <u>Frances Lazenby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>719-05-2664</u>		17. INFORMANT <u>Robert T. Blanks 111 -Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Shot gun wound thru skull</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B.) <u>Self-inflicted shot gun wound thru skull</u>					
20c. TIME OF INJURY Hour <u> </u> p.m. <u>3-29</u> 19 <u>62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Rockville Montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Franz J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>3-29-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>4/2/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springhill</u>		22d. LOCATION (City, town, or country) (State) <u>Lynchburg, Virginia</u>	
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 3 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

03815

12345

M

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03350

CERTIFICATE OF DEATH

Item 23b, Film G309 3/15/62 iwk

03343

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE California b. COUNTY San Diego	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) San Diego	
c. LENGTH OF STAY IN b. 122 days		d. STREET ADDRESS 4231 Santa Cruz Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Esther Lillian Bogenholm		4. DATE OF DEATH Month Day Year March 8, 1962	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 20, 1907
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) San Diego, California
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John P. Feeny	
14. MOTHER'S MAIDEN NAME Mary A. Hachatt		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT HUSBAND: Wilbor T. Bogenholm, Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA. 355 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) JAKOB-CREUTZFELDT SYNDROME DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 24 HOURS. 1 YR.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X (this hospital) attended the deceased from Nov. 6, 1961 to March 8, 1962 , that (X (we) last saw the deceased alive on March 8, 1962 , and that death occurred at 4:08 PM from the causes and on the date stated above.			
22a. SIGNATURE John W. Brackett Jr. M.D.		22b. DATE SIGNED March 9, 1962	
22c. PHYSICIAN'S NAME (Type) JOHN W. BRACKETT JR., LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/11/62	23c. NAME OF CEMETERY OR CREMATORY Holy Cross	23d. LOCATION (City, town or county) (State) San Diego, California
24. FUNERAL HOME OR SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR MAR 12 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

00330

00000

(1)

U. S. Army

(Major)

Chief

1st Signal Battalion

1st Signal Battalion

January 20, 1907

San Diego, California

John A. ...

John A. ...

...

...

...

...

...

...

...

...

...

...

TO HOSTAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
02351 CERTIFICATE OF DEATH 03344													
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u> c. LENGTH OF STAY in 1b <u>2 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4306 Curtis Road</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHEVY CHASE</u> d. STREET ADDRESS <u>4306 CURTIS ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>CHRISTINA ANNA BOSE</u>						4. DATE OF DEATH <u>3</u> <u>12</u> <u>1962</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 3, 1873</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>WOODRIDGE N.J.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JULIUS SANS</u>						14. MOTHER'S MAIDEN NAME <u>BARBARA ANN VOLKER</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>AGNES M. HARRIS</u> Address <u>MCDANIEL MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>527</u> IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>PULMONARY EMPHYSEMA & FIBROSIS</u> DUE TO (c) <u>ARTERIAL OCCLUSION LEFT POPLITEAL</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIAL OCCLUSION LEFT POPLITEAL</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>15 YEARS</u>													
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
22c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1959</u> to <u>MARCH 12, 1962</u> that (I) (we) last saw the deceased alive on <u>MARCH 11, 1962</u> and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Robert N. Coale</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 12, 1962</u>					
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>						22d. ADDRESS <u>4429 BRADLEY LANE, CHEVY CHASE MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
<u>Burial-Transit</u>		<u>3/15/62</u>		<u>Greenwood Cemetery</u>		<u>Brooklyn, New York</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS						25a. REC'D BY REGISTRAR <u>MAR 15 '62</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>					

00331

00331

M

4308 Curtis Road

1

Robert A. Rumbrey, Bethesda, Maryland
Bureau of Census, Washington, D.C.
Brooklyn, New York

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03352

03345

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u> <u>07</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>416 5th Ave</u>				d. STREET ADDRESS <u>416 5th Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Edwin Hinton Bowling</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-3-1900</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>E. H. Bowling</u>				14. MOTHER'S MAIDEN NAME <u>Maime Jackson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Augusta Bowling (wife)</u> <u>Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury In Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar 13-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/15/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Md. Co Va</u>	
23. FUNERAL DIRECTOR <u>Chung Chue Fong</u>				24a. REC'D BY REGISTRAR <u>Mar 15 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

2

03712

03712

03712



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02353		03346	
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>48 Bethesda (apt 210)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4405 East West Hwy. apt 210</u>		d. STREET ADDRESS <u>4405 East West Hwy</u>	
3. NAME OF DECEASED (Type or print) <u>Douglas Adair Boykin</u>		4. DATE OF DEATH Month <u>5</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-09</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salisman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ala.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Clarence Boykin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Adair</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Dorothy Boykin (wife)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic Hemorrhage</u> 976 X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Shot gun wound in left chest (heart)</u> (c) <u>Shot gun wound in left chest (heart)</u> DUE TO cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted shot gun wound (12 gauge)</u>	
20c. TIME OF INJURY Hour <u>2</u> p.m. Month, Day, Year <u>3-5 1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bremination</u>		22b. DATE THEREOF <u>3/7/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>9 '62</u> 24b. REGISTRAR'S SIGNATURE <u>William E. Hanna</u>	

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03354

03347

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in lb <u>5 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>5401 Galena Pl., N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>A.</u> Last <u>Boyle</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/87</u>		9. AGE (in years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>74</u> Days <u>74</u>	IF UNDER 24 HRS. Hours <u>74</u> Min. <u>74</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas Boyle</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Casey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Elva Boyle, wife</u> Address <u>same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE UREMIA</u> <u>550</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>RUPTURED APPENDIX WITH PERITONITIS</u> DUE TO (c) <u>7 DAYS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>7 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> e.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>See</u> , 19 <u>50</u> , to <u>March</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>3/19</u> , 19 <u>62</u> , and that death occurred at <u>1P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Leo I Donovan M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEO I DONOVAN M.D.</u>				22d. ADDRESS <u>8211 WISC AVE BETH 14 MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAR. 23, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		23d. LOCATION (City, town or county) <u>WASHINGTON</u>		(State) <u>D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>				ADDRESS <u>2224-Wisc Ave</u>		25a. REC'D BY REGISTRAR <u>MAR 22 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>			

08387

82224

14

1

Alton. Ref of 22-1-1940
MAR 22 1940
WASHINGTON D C

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03355 CERTIFICATE OF DEATH 03348

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>49 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>1309 South Taylor Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Chester</u> Last <u>Braun</u>				4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>19 62</u>																							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>24 June 1902</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>															
13. FATHER'S NAME <u>George Braun</u>						14. MOTHER'S MAIDEN NAME <u>Josephine Slater</u>																					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>173-12-6576</u>				17. INFORMANT <u>The Medical Record, The Clinical Center, Bethesda 14, Maryland</u>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated Duodenal Ulcer with peritonitis</u> DUE TO <u>181-06</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Advanced Carcinoma of Bladder</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 - 7 days</u> <u>2 yrs. 9 mos.</u>															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that (he) (this hospital) attended the deceased from <u>Feb. 2, 1962</u> to <u>March 23, 1962</u> that (it) (we) last saw the deceased alive on <u>March 23, 1962</u> and that death occurred at <u>10:45 AM</u> from the causes and on the date stated above.																											
22a. SIGNATURE <u>Yosef H. Pilch</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>March 23, 1962</u>				22b. DATE SIGNED																			
22c. PHYSICIAN'S NAME (Type) <u>Yosef H. Pilch, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>				22e. REC'D BY REGISTRAR <u> </u> 22f. REGISTRAR'S SIGNATURE <u> </u>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3-25-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>				23d. LOCATION (City, town or county) (State) <u>Luray Virginia</u>															
24. FUNERAL DIRECTOR'S SIGNATURE <u>DM Cickenberger</u> <u>Sienna Virginia</u>																											

100000

100000



100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

100000

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03356 CERTIFICATE OF DEATH 03349

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>19 TAKOMA PARK</u> d. STREET ADDRESS <u>8600 Glenview Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Tillman Britt</u>		4. DATE OF DEATH <u>3</u> <u>24</u> <u>19 62</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-20</u>
9. AGE (In years last birthday) <u>42 yrs.</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>24</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Main Tenance - Library of Cong</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. Britt</u>		14. MOTHER'S MAIDEN NAME <u>Eva M. Sullivan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, give year or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Hospital Record.</u>	
17. INFORMANT <u>Hospital Record.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> 5818 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Advanced Cirrhosis of Liver</u> (c) <u>6 years</u> DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Bronchopneumonia Severe Hypoalbuminemia Hypoproteinaemia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Aug 13, 1956</u> to <u>March 24, 1962</u> that (I) <u>(last)</u> saw the deceased alive on <u>March 23, 1962</u> and that death occurred at <u>3:59 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Russell B. Arnold</u> M.D.		22b. DATE SIGNED <u>3/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		22d. ADDRESS <u>8801 Colisville Road, Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 27-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Adelphi Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		25. REC'D BY REGISTRAR <u>MAR 28 62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		DATE	

03319

CERTIFICATE OF DEATH

63328

(M)

(T)

born at 11 months

Hepatic Cirrhosis

Chronic and Catarrhal of Liver

Presumptive cause of death

March 23, 1900

Dr. J. H. Smith, M.D.
San Antonio, Tex.
Chief Medical Officer
of the City of San Antonio, Tex.
March 23, 1900

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03357 CERTIFICATE OF DEATH 03350

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 24</u> d. STREET ADDRESS <u>604 Bonivant Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bernice Clara Broome</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>20</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-01</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Indian</u>	11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>
13. FATHER'S NAME <u>McClain</u>		14. MOTHER'S MAIDEN NAME <u>Not Available</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH <u>3/18/62</u> <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/1/61</u> , 19 <u>52</u> to <u>3/20/62</u> , that (I) (we) last saw the deceased alive on <u>3/20/1962</u> , and that death occurred at <u>3:05</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard T Morse</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3/20/62</u>
22c. PHYSICIAN'S NAME (Type) <u>Howard T Morse</u>		22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 23, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>254 Carroll St. NW, Wash, D.C.</u>		DATE <u>MAR 22 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be event within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician

VR A1
15M S

CERTIFICATE OF DEATH

03358

03351

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rockville, Maryland</u>		d. STREET ADDRESS <u>705 Marshall Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lyda</u>		First <u>Lyda</u> Middle <u>mae</u> Last <u>Broome</u>		4. DATE OF DEATH Month <u>mar</u> Day <u>22</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 3, 1919</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Columbia S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William P. Suggert</u>				14. MOTHER'S MAIDEN NAME <u>LYDA Roberts</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-14-9440</u>		17. INFORMANT <u>Milton Broome - 705 Marshall Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Toxemia</u> , hemorrhage <u>274 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>adrenal cortical failure</u> DUE TO (c) <u>stress ulcer (gastric), intestinal fistulas</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>previous advanced cancer uterus, fistulas</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>6 yrs</u>			
22a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>		22c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		22f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1-5-52</u> , 19 <u>52</u> to <u>3-22</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3-21</u> , 19 <u>62</u> and that death occurred at <u>11:35</u> AM, from the causes and on the date stated above							
22a. SIGNATURE <u>John O Robben</u>				22b. DATE SIGNED <u>3/23/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN O. ROBBEN</u>				22d. ADDRESS <u>1015 Spring St Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/26/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY INC. 8434</u> <u>Raymond A. Ziska</u>				ADDRESS <u>GEORGIA AVE E., SILVER SPRING MD.</u>		25a. REC'D BY REGISTRAR <u>MAR 27 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

5 director, page 3 should be detached for use as the burial-transit permit. Then please remove cartoon papers. Pages 1 and 2 should
6 be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.
7 (4)

5 (4)
p/60

1880

2282

M

I

1880-1881

JOHN O. ROBERT

JOHN O. ROBERT

JOHN O. ROBERT

JOHN O. ROBERT

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03359												03352	
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN b. 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 4302 Ferrara Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Donald Kenneth Brown						4. DATE OF DEATH March 24, 1962							
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 18, 1922		9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harry Jesse Brown						14. MOTHER'S MAIDEN NAME Edna Viola Wearth							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 538 26 9705		17. INFORMANT WIFE: Mrs. Edna P. Brown, Same as #2		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 430-1 DUE TO (b) Coronary insufficiency Conditions, if any, which gave rise to immediate cause (c) Arteriosclerosis (e), stating the underlying cause last. DUE TO (c) Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 25 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 23, 1962 to March 24, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 24, 1962 , and that death occurred at 11:02 AM on the causes and on the date stated above.													
22a. SIGNATURE Joseph H. Eusterman M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 24, 1962					
22c. PHYSICIAN'S NAME (Type) JOSEPH H. EUSTERMAN LT MC USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-30-62		23c. NAME OF CEMETERY OR CREMATORY Ivy Lawn Cemetery		23d. LOCATION (City, town or county) (State) Oxnard, California							
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Funeral Home, 1400 Chapin St. NW						ADDRESS Wash., D.C.		25a. REC'D BY REGISTRAR DATE MAR 28 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

WW Chambers

(M)

03258

03258

Monterey

Marina

Boards (Naval)

Alvin Spring

U. S. Naval Hospital

102 Fortuna Drive

Donna

Brown

March 18, 1962

X

Unassisted

January 18, 1962

Naval Officer

Washington

Harry Jacob Brown

John Viola Brown

Yes

288 26 3705

Wife: Mrs. John F. Brown, same as 12

Handwritten signature

March 18, 1962

March 18, 1962

Handwritten signature

JOHN F. BROWN JR. 10 100

U. S. Naval Hospital, Bethesda, Md.

3-10-62

20141

W. W. Thompson, Personal Name, 1400 Chapin St. N.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03353

03350

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u> LENGTH OF STAY IN 1b <u>11 days</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>32 Silver Spring</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>32 Silver Spring</u> d. STREET ADDRESS <u>609 Univ. Blvd. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Peter</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-93</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plate Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert J. Brown</u>	
14. MOTHER'S MAIDEN NAME <u>Isabel F Rice</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Washington San. & Hosp. Takoma Park Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyipostatic Pneumonia</u> <u>3222X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Cerebral Vascular Occlusion</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystectomy (Status Post)</u> 3-8-62			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 17, 1962</u> to <u>Mar 18, 1962</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Mar 18, 1962</u> and that death occurred at <u>5:25 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John P. Haberlin</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3/18/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John P. Haberlin</u>		22d. ADDRESS <u>1015 Spring St Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-21-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince George's Co, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zick</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 20 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Clifford S. House</u>
Warner E. Pumphrey, Inc, Silver Spring, Maryland			

00000

00000

M

Philip

Male

Plate 1000

Robert J. Brown

No

Isabel F. Rice

Chas.

W. S. H.

08334

08334



Handwritten signature

3-9-42
H. L. ...

TO HOSPITAL OF DEATH. The law requires that the death certificate be executed 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03362						03355							
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>231 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, 14, Md.</u>						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <u>Pennsylvania</u> b. COUNTY <u>Harrisburg,</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1720 North 3rd Street,</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Jane Charlotte Burley</u>						4. DATE OF DEATH <u>March 22, 1962</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>14 July 1921</u>		9. AGE (In years last birthday) <u>40 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Paul Timothy</u>						14. MOTHER'S MAIDEN NAME <u>Catherine Rice</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>Not available</u>						17. INFORMANT <u>The Medical Record,</u> <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterial Hypertension</u> <u>152.7</u> DUE TO (b) <u>Malignant Carcinoid (primary tumor of the distal ileum)</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Pneumothorax, left</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 Hours</u>													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>August 3, 1961, to March 22, 1962</u> , that <u>he</u> (we) last saw the deceased alive on <u>March 22, 1962</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Michael Field</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>3-23-62</u>			22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>Michael Field M.D.</u>						22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/26/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Harrisburg Cem.</u>		23d. LOCATION (City, town or county) <u>Harrisburg, Penna.</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>MAR 27 '62</u>		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

2

I

50

M

VR A15 (4)
15M 9/60

08855

08855



The Office of the
Director of the
Bureau of the
Census
Washington, D.C.
February 1, 1954
Dear Sir:
Enclosed for you are
two copies of the
Annual Report of the
Bureau of the Census
for the year 1953.
One copy is being
sent to the
Library of Congress
and the other to the
National Archives.
Very truly yours,
Director



Enclosed for you are
two copies of the
Annual Report of the
Bureau of the Census
for the year 1953.
One copy is being
sent to the
Library of Congress
and the other to the
National Archives.

Very truly yours,
Director
Enclosed for you are
two copies of the
Annual Report of the
Bureau of the Census
for the year 1953.
One copy is being
sent to the
Library of Congress
and the other to the
National Archives.

Handwritten signature

Enclosed for you are
two copies of the
Annual Report of the
Bureau of the Census
for the year 1953.
One copy is being
sent to the
Library of Congress
and the other to the
National Archives.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03363 CERTIFICATE OF DEATH 03356

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1206 - Noyes Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jewel De Maria Burns</u>		4. DATE OF DEATH Month Day Year <u>3 1 12 1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/99</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin De Maria</u>		14. MOTHER'S MAIDEN NAME <u>Josephine De Pasquale</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-36-0723H</u>	
17. INFORMANT <u>Edward A. Burns</u>		Address <u>1206 Noyes St. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <u>Carcinoma of Breast & Metastasis</u> DUE TO <u>Acute Heart Failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>170X</u> DUE TO <u>6 years</u> <u>6 mos.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/11</u> , 19 <u>55</u> to <u>3/12</u> , 19 <u>62</u> ; that (I) (<u>we</u>) last saw the deceased alive on <u>3/12</u> , 19 <u>62</u> , and that death occurred at <u>4:15</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John E. Everett</u> M.D.		22b. DATE SIGNED <u>3/12/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		22d. ADDRESS <u>9400 CONN AVE Kensington Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-16-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Silver Spring Montgomery Co., Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jones</u>		25. REC'D BY REGISTRAR <u>Arthur S. Hanna</u>	
25a. ADDRESS <u>Warner E. Pumphrey, Inc., Silver Spring, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15M
5M 9/60

03364

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03357

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>mntg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville (rural)</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville - 13 03</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Old Balto. Rd</u>				d. STREET ADDRESS <u>Old Balto. Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maggie Stanton Butler</u>				4. DATE OF DEATH Month Day Year <u>Mar 16 1962</u>			
5. SEX <u>Female</u>	6. COLOR OF RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-1868</u>		9. AGE (In years last birthday) <u>93</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Harry Stanton</u>				14. MOTHER'S MAIDEN NAME <u>Elybeth Snowden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Nella Welsh - Stoner</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>yes,</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>3-16-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/20/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>	
				22d. LOCATION (City, town, or country) <u>Damascus, Md.</u>		(State)	
23. FUNERAL DIRECTOR <u>Robert L. Surver</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

MEDICAL CERTIFICATION

10000

10000

M

10000

10000

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
03365 Item 2 CERTIFICATE OF DEATH Film G308 3/14/62 iwk 3/16/62 iwk 03358															
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Washington, D.C.</u> d. STREET ADDRESS <u>35 Morrison St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Franklin</u> Last <u>Butler</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1962</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Photographer</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Franklin Butler</u>				14. MOTHER'S MAIDEN NAME <u>Augusta E. Buck</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>none</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Washington Sanitarium and Hospital</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gallstones choleliths</u> <u>5 8 5 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>CIRRHOSIS OF LIVER</u>				INTERVAL BETWEEN ONSET AND DEATH <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>aneurysm of abdominal aorta</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>											
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>					
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 28</u> 19 <u>62</u> to <u>Mar 3</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Mar 2</u> 19 <u>62</u> , and that death occurred at <u>2:35 AM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>Leonard L. Deitz</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4/5/62</u>											
22c. PHYSICIAN'S NAME (Type) <u>LEONARD L. DEITZ</u>				22d. ADDRESS <u>800 PERSHING DR SILVER SPRING MD</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3/5/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>				23d. LOCATION (City, town or county) (State) <u>md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Salomoni</u>				25. REC'D BY REGISTRAR DATE <u>MAR 8 '62</u>				25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>							

100000

100000



Department of Agriculture
Circular No. 1000

Department of Agriculture

100000

100000

100000

100000

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of the retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03365

03359

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in lb <u>22 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u> d. STREET ADDRESS <u>1219 Highland Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY</u> <u>Boy</u> <u>BUTT</u> First Middle Last DATE OF DEATH <u>March 20</u> 19 <u>62</u> Month Day Year		8. DATE OF BIRTH <u>3/19/62</u> 9. AGE (In years last birthday) <u>22</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HARRY PRESTON BUTT</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u>		14. MOTHER'S MAIDEN NAME <u>BERNICE GEORGIA BURKE</u> 17. INFORMANT <u>MOTHER</u> Address <u>(SAME AS ABOVE)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Anoxia</u> <u>761.5</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Premature separation of Placenta.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work el work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> 19 <u>62</u> to <u>3/20</u> 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>3/19</u> 19 <u>62</u> , and that death occurred at <u>12:00</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>James S. Stanton</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>JAMES S STANTON</u>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>809 Viers Hill Rd Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>3-21-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u> 23d. LOCATION (City, town or county) (State) <u>BETHESDA, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Amelia C. Carter, Admin. (per A.B.)</u> ADDRESS <u>Suburban Hospital Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 22 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

2-067834

03329

03328

M

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03367

03360

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY in lb <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bella Vista Nursing Home</u>			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1809 Owens Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <u>Frances C. Carroll</u>			4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1962</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
8. DATE OF BIRTH <u>11-28-1892</u>		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>							
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William M. Carroll</u>			14. MOTHER'S MAIDEN NAME <u>Mary Alice</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO. <u> </u>								
17. INFORMANT <u>Clarence Carroll - 1809 Owens Rd</u>			Address <u>oxon Hill Md</u>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Acidosis</u> DUE TO <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>Years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Senility</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 8, 1962</u> to <u>March 9, 1962</u> that (I) (we) last saw the deceased alive on <u>March 8, 1962</u> and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Philip E. Jones</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/9/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>						22d. ADDRESS <u>918 Ellsworth Drive SE</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Mar. 12-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			23d. LOCATION (City, town or county) <u>Sutland Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>						25a. REC'D BY REGISTRAR <u>1661 Wood Hope Rd SE</u> <u>WASH DC</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

02550

4750

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
(M)

90

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03368					03361				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Montgomery, MARYLAND					a. STATE Mass. b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington,				c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carol Hall Sant.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Malden				58x-3
d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			
EVA			M			CARTER			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1874		9. AGE (In years last birthday) 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Nova Scotia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Sylvias Mosher					14. MOTHER'S MAIDEN NAME Eunice Dinsmore				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 015-26-5480		17. INFORMANT E.N. Read-6905 Maple Ave. Chev. Ch., Md			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF MOUTH 144X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 29, 1960 to MARCH 19, 1962 that (I) (we) last saw the deceased alive on MARCH 19, 1962 and that death occurred at 445 AM from the causes and on the date stated above.									
22a. SIGNATURE Henry Sander					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/19/62
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS 5206 NORWAY DR CHEVY CHASE, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/21/62		23c. NAME OF CEMETERY OR CREMATORY Puritan Lawn Mem. Pk.			23d. LOCATION (City, town or county) (State) West Peobody, Mass.		
24. FUNERAL DIRECTOR'S SIGNATURE J. W. - Kees					ADDRESS Wash. D.C.		25a. REC'D BY REGISTRAR DATE MAR 22 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline

NAVED

88050



RECEIVED
NAVY DEPARTMENT
WASHINGTON, D.C.

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

NAVY DEPARTMENT

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03369
CERTIFICATE OF DEATH
03362

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK, MD c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SANITARIUM & HOSP				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE, 1650-2 d. STREET ADDRESS 5906 -14TH. PLACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOHN L. CASHELL				4. DATE OF DEATH March 27 1962					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 1, 1910			
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.					
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HARRY M. CASHELL				14. MOTHER'S MAIDEN NAME FANNIE L. LAVELL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 57-22-3062					
17. INFORMANT Mrs. Mrs. M. Casshell				Address Same as #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 420. DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Myocardial Infarction								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from Feb 1956 to March 27, 1962 , that (I) (we) last saw the deceased alive on March 27, 1962 , and that death occurred at 7:30 PM , from the causes and on the date stated above.									
22a. SIGNATURE Richard L. Whelton M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 27, 1962			
22c. PHYSICIAN'S NAME (Type) RICHARD L. WHELTON				22d. ADDRESS 1021 University Blvd ES Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-31-62		23c. NAME OF CEMETERY OR CREMATORY mt Olivet cemetery		23d. LOCATION (City, town or county) Washington, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS 3821-14TH. ST. N.W. Wash. D.C.				25. REC'D BY REGISTRAR APR 2 '62		25. REGISTRAR'S SIGNATURE Arthur L. Evans			

00000

00000

MARYLAND James G. Thompson

HARRISVILLE

1906 - 1907

WASHINGTON, D.C. 1906

FANNIE L. LARSEN

1906 - 1907

U.S. GOVT.

HARRY M. LARSEN

1906

1906 - 1907

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
003370
003363

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waverly d. STREET ADDRESS Route # 3, Box 377	
3. NAME OF DECEASED (Type or print) Anna Jane Cassady		4. DATE OF DEATH Month March Day 12 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 2, 1924
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby Sitter		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rush Cassady		14. MOTHER'S MAIDEN NAME Elma Bond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cardiac arrest 754.0 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Congestive heart failure following operation: teflon graft anastomosis between left subclavian artery and left pulmonary artery (c) Corrected transposition of great vessels with left-	
19. INTERVAL BETWEEN ONSET AND DEATH 17 days		20. (Cont.) sided Ebstein's phenomenon and tetralogy of fallot and	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) atrial septal defect	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from January 17, 1962 , to March 12, 1962 , that (X) (we) last saw the deceased alive on March 12, 1962 , and that death occurred at 5:20 PM from the causes and on the date stated above.			
22a. SIGNATURE W. B. Berry		22b. DATE SIGNED 3/13/62	
22c. PHYSICIAN'S NAME (Type) W. B. Berry, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE THEREOF 3/15/62	
23c. NAME OF CEMETERY OR CREMATORY Cassady Cemetery		23d. LOCATION (City, town or county) Inez, Kentucky	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 15 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			



1 V

It is a very good idea to have a copy of this letter in your file.

§ 105. 7

24

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03371

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03364

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution, Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash Sant Hosp</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>40 Silver Spring</u>	
3. NAME OF DECEASED (Type or print) <u>Henri Louis Chamberland</u>		d. STREET ADDRESS <u>12109 Dexter St</u>	
4. DATE OF DEATH <u>3-6-1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-10</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY Dept</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ALEX CHAMBERLAND</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE OUELLETTE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes 2nd WW</u>		16. SOCIAL SECURITY NO. <u>579-40-9687</u>	
17. INFORMANT <u>ANN Chamberland</u>		Address <u>Same as deceased</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME-OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Blumenthal</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Blumenthal</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-10-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town or country) (State) <u>Montgomery County Maryland</u>	
23. FUNERAL DIRECTOR <u>Francis J. Collins</u>		24a. REC'D BY REGISTRAR <u>WAR 9/62</u>	
ADDRESS <u>3821-14th St. NW, Wash, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

03381

03381



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03372
CERTIFICATE OF DEATH
03365

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 30 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9306 Flower Avenue		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Silver Spring d. STREET ADDRESS 9306 Flower Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle C Last Childs		4. DATE OF DEATH Month March Day 9 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1897
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Louisiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Cole	
14. MOTHER'S MAIDEN NAME Elizabeth Frances Eastman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Leroy M. Childs Address 9306 Flower Ave, Silver Spring Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cot Pulmonale 527.1 DUE TO Pulmonary Emphysema Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		INTERVAL BETWEEN ONSET AND DEATH 8 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from 1951 to March 9, 1962 that (I) we last saw the deceased alive on March 5, 1962 and that death occurred at 1 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John W. Trenis		22b. DATE SIGNED 3-9-62	
22c. PHYSICIAN'S NAME (Type) John W. Trenis		22d. ADDRESS 1150 Connecticut Ave, N.W., Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-12-62	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery	23d. LOCATION (City, town or county) Olney Montgomery Maryland (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zick		25a. REC'D BY REGISTRAR Warner E. Pumphrey, Inc. Silver Spring, Maryland	25b. REGISTRAR'S SIGNATURE Charles L. Hines

03365

03365



James L. Murphy, Inc. River Springs, Maryland
John L. Murphy, Inc. River Springs, Maryland

03373

CERTIFICATE OF DEATH

Reg. Dist. No. 03366

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase Village</u>				c. LENGTH OF STAY IN 1b <u>50 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>21 West Irving Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Swingle Clark</u>				4. DATE OF DEATH <u>March 30, 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 4, 1876</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert Duncan Swingle</u>		14. MOTHER'S MAIDEN NAME <u>Emma Catherine Johnston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Charles C. Clark Jr., 403 Perry St., Fairfax, Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>331X</u> (c) <u>3+ yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>10</u> a. m. <u>30</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5522 Western Ave</u>	
20f. (City or town) <u>Washington, D.C.</u>				(County) <u>D.C.</u> (State) <u>D.C.</u>			
21. I certify that I attended the deceased from <u>10 DEC. 1960</u> to <u>30 MAR. 1962</u> that I last saw the deceased alive on <u>28 MAR. 1962</u> and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. H. Richwine</u> M.D.				DATE SIGNED <u>31 MAR. 1962</u>			
PHYSICIAN'S NAME (Type) <u>A. H. RICHWINE, M.D., Ch. Ch. 15, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/3/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>				24a. REC'D BY REGISTRAR <u>APR 3 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

03873

CERTIFICATE OF DEATH

03873

M

[Faint, illegible text, likely bleed-through from the reverse side of the document. The text appears to be a narrative or a list of events.]

TO HOST: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03374 CERTIFICATE OF DEATH 03367

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 4517 Willard Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Chevy Chase		d. STREET ADDRESS 4517 Willard Avenue	
3. NAME OF DECEASED (Type or print) Addie				4. DATE OF DEATH 3 11 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/10/78	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Gov't, Ret				11. BIRTHPLACE (County & State, or foreign country) Washington, DC			
13. FATHER'S NAME William Martin				14. MOTHER'S MAIDEN NAME Olivia Walker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Fannie C. Scott-daughter-same 2d			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ADVANCING YRS						INTERVAL BETWEEN ONSET AND DEATH 10 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE, 1956 to MARCH, 1962 , that (I) (we) last saw the deceased alive on 3/8, 1962 , and that death occurred at 4P M, from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/15/62	
22c. PHYSICIAN'S NAME (Type) LIEUT DONOVAN M.D.				22d. ADDRESS 8218 WILCOX AVE BETHESDA MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/13/62		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				25a. REC'D BY REGISTRAR MAR 15 '62		25b. REGISTRAR'S SIGNATURE [Signature]	

(M)

(I)

00377

00387

Montgomery

Montgomery

Heavy Gun

Heavy Gun

217th Infantry

217th Infantry

Infantry

Infantry

Female White

Female White

U. S. Gov't. Lab

U. S. Gov't. Lab

William Martin

William Martin

None

None

Glenn G. Gentry

Glenn G. Gentry

5/15/62

Robert A. Humphrey, Bethesda, Maryland

TO HOSTEL: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03375 CERTIFICATE OF DEATH 03368

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHEATON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington DC	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BEL PRE NURSING HOME		d. STREET ADDRESS 2330 Skyland Pl., S.E.	
3. NAME OF DECEASED (Type or print) First IDA Middle E Last Cooley		4. DATE OF DEATH Month MARCH Day 20 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUGUST 11, 1896
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. Store		12. KIND OF BUSINESS OR INDUSTRY SALESLADY	
13. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.		14. CITIZEN OF WHAT COUNTRY? U.S.	
15. FATHER'S NAME William Z. Howard		16. MOTHER'S MAIDEN NAME MARY SMITH	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		18. SOCIAL SECURITY NO. MR. RICHARD COOLEY, 11333 Schuykill Rockv.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 199X DUE TO Metastatic Cancer to Brain & Spinal Cord Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Cancer, primary site unknown Prob. Kidney or Pancreas		INTERVAL BETWEEN ONSET AND DEATH 8 Months 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 61 , to 3/20 , 19 62 , that (I) (we) last saw the deceased alive on 3/19 , 19 62 , and that death occurred at 2:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Max G. Sherer M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) MAX G. SHERER, MD		22b. ADDRESS 2025 EAST West H'way Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 23-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Southland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros Funeral Home		25a. REC'D BY REGISTRAR DATE MAR 21 '62	
ADDRESS 1661 - Good Hope Rd SE WASH DC		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

03383

ESTIMATE OF DEATH

1977

(M)

WHEATON

DEPT OF AGRICULTURE

1977

WHEATON

DEPT OF AGRICULTURE

WHEATON

WHEATON

WHEATON
DEPT OF AGRICULTURE
WHEATON

WHEATON

WHEATON

WHEATON

WHEATON

WHEATON
DEPT OF AGRICULTURE
WHEATON

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03376		Item 4 Film 0309 3/19/62 jwk		03369	
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville,		c. LENGTH OF STAY IN 1b 214 Frederick Ave.,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 214 Frederick Ave.,		e. STATE Maryland		f. COUNTY Montgomery	
3. NAME OF DECEASED (Type or print) MILROY		First C.		Middle COOPER	
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF DEATH March 5,		9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Henson Carroll	
14. MOTHER'S MAIDEN NAME Florence Hayes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Nelson Cooper		Address Item # 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO (b) Arteriosclerotic hypertensive cardiovascular disease (c) Left Hemiplegia in 1957 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) none	
19. INTERVAL BETWEEN ONSET AND DEATH 1 month		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. I certify that (I) (this hospital) attended the deceased from 1957 , to March 5, 1962 , that (I) (we) last saw the deceased alive on March 5, 1962 , and that death occurred March 5, 1962 , from the causes and on the date stated above.	
22a. SIGNATURE W. L. Lintner		22b. DATE SIGNED 3/6/62		22c. PHYSICIAN'S NAME (Type) W. A. Lintner	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-9-62		23c. NAME OF CEMETERY OR CREMATORY St. Marys,	
23d. LOCATION (City, town or county) Rockville, Md		23e. REC'D BY REGISTRAR MAR 14 '62		23f. REGISTRAR'S SIGNATURE Arthur S. Thayer	

02000

02000

(M)

viewing

viewing

..1117.002

..1117.002

..1117.002

..1117.002

..1117.002

..1117.002

..1117.002

..1117.002

..1117.002

..1117.002

(1)

Handwritten notes at the bottom of the page, including "1117.002" and other illegible text.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other person is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bellsville c. LENGTH OF STAY in lb 05 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Hunter Rd					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bellsville (rural) d. STREET ADDRESS Hunter Rd. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Pernell Middle Cooper Last Cooper					4. DATE OF DEATH Month March Day 11 Year 19 62				
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/3/62		9. AGE (in years last birthday) 1 yrs. IF UNDER 1 YEAR Months 1 Days 8 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Cooper					14. MOTHER'S MAIDEN NAME Edith Harper				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Police Report Address 			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 475X DUE TO Upper Respiratory Infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								INTERVAL BETWEEN ONSET AND DEATH Found dead in bed	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Mar. 11, 1962 DATE SIGNED Mar. 11, 1962				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/14/62		22c. NAME OF CEMETERY OR CREMATORY Elijah Church Cemetery, Poolesville, Md.			22d. LOCATION (City, town, or country) (State)		
23. FUNERAL DIRECTOR Robert L. Snowden ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR MAR 15 '62 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Knease			

2-028039

000000



1933

11 11

10000

10000

1 1

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03378

03371

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3154 Tennyson Street, N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gail Walden Crossen				4. DATE OF DEATH 3/26/62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/26/93	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 4 Days 7		IF UNDER 24 HRS. Hours 3 Mln. 3			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banker retired				10b. KIND OF BUSINESS OR INDUSTRY Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel I. Crossen				14. MOTHER'S MAIDEN NAME Helena Theresa Horn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Helena A. Crossen (wife) Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary occlusion 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-26-62 Address (Street, city, town, or county)							
ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) FRANK J. Broschart					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/62		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or country) (State) Washington, D. C.	
23. FUNERAL DIRECTOR Robert A. Humphrey Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE MAR 30 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

99

1

0

2

03871

03871



TO HOSPITAL
death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03379

03372

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4300 Glenrose St.</u>	
3. NAME OF DECEASED (Type or print) <u>Helen Marie Marie Crossette</u>		4. DATE OF DEATH <u>March 15, 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Pearce</u>		14. MOTHER'S MAIDEN NAME <u>Clara White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>George Crossette-Son-same 2d</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Antero-septal</u> <u>4-20-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } DUE TO <u>Coronary sclerosis</u> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>3:19</u> <u>1962</u> to <u>3:15</u> <u>1962</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>3:14</u> <u>1962</u> , and that death occurred at <u>1:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Stewart Clapp M.D.</u>		22b. DATE SIGNED <u>3-15-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>		22d. ADDRESS <u>4740 Chevy Chase Dr Chevy Chase Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/19/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Thomas</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>MAR 16 '62</u>	

03875

03875



Robert A. Humphrey, Bethesda, Maryland
Williamson, New York
Admission, Virginia

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH															
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
03380 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03373															
Items 13 & 14 File 6300 3/22/62															
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>06 Germantown (rural)</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Violet Lock Rd.</u>				d. STREET ADDRESS <u>Violet Lock Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Paul A. Czichos</u>			First Middle Last			4. DATE OF DEATH <u>Mar. 9, 1962</u> <u>19</u>			Month Day Year						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6/15/97</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. service (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>ALVIN Texas</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Frank Czichos</u>						14. MOTHER'S MAIDEN NAME <u>Rosa M. Plentl</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WW 1 & 2</u>				16. SOCIAL SECURITY NO. <u>452 36 3531</u>				17. INFORMANT <u>Police report</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ (e), stating the underlying cause last. } DUE TO												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>Mar. 9, 1962</u>							
EXAMINER'S NAME (Type) <u>Frank J. Broschart, Gaithersburg</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-14-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) <u>Arlington Va.</u>		(State)					
23. FUNERAL DIRECTOR <u>Ernest C. Gartner, Gaithersburg, Md.</u>						ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 15 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hane</u>					

07373

00338

(N)

()

24 hours after death. Page 4 retained by the hospital or attending physician.
TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03381

CERTIFICATE OF DEATH
Item 2 Film G508 3/12/62 iwk

03374

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville/ Silver Spring d. STREET ADDRESS 806 Wayne Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle D Last Darby		4. DATE OF DEATH Month March Day 1 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 4 1869 92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 92 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME THOMAS DARBY		14. MOTHER'S MAIDEN NAME ELIZABETH DAWSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr Gordon DARBY - Son		Address 806 Wayne Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Serious DUE TO (b) Serious DUE TO (c) Serious		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 9, 1958 to Mar 1, 1962 , that (I) (we) last saw the deceased alive on Mar 1, 1962 and that death occurred at 4 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Oliver E Thompson M.D.		22b. DATE SIGNED 3-1-62	
22c. PHYSICIAN'S NAME (Type) Dr. Oliver Thompson		22d. ADDRESS 901 Poolesville Rd Silver Spring	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/3/62	23c. NAME OF CEMETERY OR CREMATORY Monocacy	23d. LOCATION (City, town or county) (State) Boallsville, Md.
24. FUNERAL DIRECTOR'S SIGNATURE William E. Hill ADDRESS Barnesville, Md.		25a. REC'D BY REGISTRAR Mar 6 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

1892

1892

1892

1892

1892

1892

1892

1892

1892

1892

1892

1892

1892

1892

X

1892

1892

1892

1892

1892

1892

08332

08332

(M)

(J)

100

TO HOSPITAL DEATH. Page 4. ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03383 CERTIFICATE OF DEATH 03376

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 189 days,		d. STREET ADDRESS 950 25th Street NW	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Jeanette Davis		4. DATE OF DEATH Month Day Year March 19, 19 62	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 3, 1903
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Sullivan		14. MOTHER'S MAIDEN NAME Nettie C. Owens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. p - - - -	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 14 7 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from Sept. 11, 1961, to March 19, 1962, that (he) (we) last saw the deceased alive on March 19, 1962, and that death occurred at 1:00 AM from the causes and on the date stated above.			
22a. SIGNATURE William C. Monell		22b. DATE SIGNED March 19, 1962	
22c. PHYSICIAN'S NAME (Type) WILLIAM C. MONELL LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 22 March 1962	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE DEVOL Funeral Home		25a. REC'D BY REGISTRAR MAR 22 '62	
25b. REGISTRAR'S SIGNATURE Curtis L. Hume			

03323

03323

(1941) (1941)

U. S. Naval Hospital

1941

Continuing

Continuing

Continuing

No

U. S. Naval Hospital

1941

1941

U. S. Naval Hospital

U. S. Naval Hospital

1941

1941

1941

1941

U. S. Naval Hospital

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03384

03377

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 30 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 36 Kensington d. STREET ADDRESS 3112 McComas Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Argent Elaine Denniston				4. DATE OF DEATH March 14, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 November 1959	
9. AGE (In years last birthday) 2 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles L. Denniston, Jr.				14. MOTHER'S MAIDEN NAME Rosemary Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record,				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiorespiratory Failure 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute Myelocytic Leukemia DUE TO (c) respiratory INTERVAL BETWEEN ONSET AND DEATH 7 Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from Feb. 12 1962 to March 14 1962 , that (A) (we) last saw the deceased alive on March 14 1962 , and that death occurred at 1:45 PM from the causes and on the date stated above.							
22a. SIGNATURE Geo. H. Porter, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3-14-62	
22c. PHYSICIAN'S NAME (Type) George H. Porter				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/15/62		23c. NAME OF CEMETERY OR CREMATORY Columbia S.C.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Washington D.C.				25a. REC'D BY REGISTRAR 14008 Bishop St		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

2

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4, and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03377

03377



... ..

... ..



... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

03385

CERTIFICATE OF DEATH

Reg. Dist. No. 03378

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last J. EDWARD DOMKE		4. DATE OF DEATH Month Day Year MARCH 11 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/68
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 11 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-retired		10b. KIND OF BUSINESS OR INDUSTRY Selling	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 470-12-8447	
17. INFORMANT Adelaide W. Domke-wife-same above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF INTESTINES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF PROSTATE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 15, 1962 to MARCH 11, 1962 that I last saw the deceased alive on MARCH 11, 1962 and that death occurred at 8:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry M. Lowden M.D.		ADDRESS (Street, city or town, state) 5206 Norway Drive, Chevy Chase, Md.	
PHYSICIAN'S NAME (Type) Henry M. Lowden		DATE SIGNED 3/16/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/12/62	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 14 '62	
24b. REGISTRAR'S SIGNATURE William S. Thomas			

TO HOSPITAL OR NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03328

CERTIFICATE OF DEATH

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO HO... ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 2 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03386 Item 8 & 23b, Film G309 3/22/62 iwr 03379

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE District of Columbia District of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. NAVAL HOSPITAL			d. STREET ADDRESS 3500 Neward St., N.W.		
3. NAME OF DECEASED (Type or print) Benjamin Henry Dorsey			4. DATE OF DEATH Month March Day 17 Year 1962		
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 13, 1877		
9. AGE (In years last birthday) 84			10. IF UNDER 1 YEAR Months 4 Days 7 Hours 8 Min. 3		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer			11. BIRTHPLACE (County & State, or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Joshua W. Dorsey		
14. MOTHER'S MAIDEN NAME Elenor E. Watkins			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		
16. SOCIAL SECURITY NO.			17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause leading for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Lobar 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) Intestinal obstruction, Cause unknown (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 21 1962 to Mar 17 1962 , that (I) (we) last saw the deceased alive on 17 March 1962 , and that death occurred at 4:20 P.M. from the causes and on the date stated above.					
22a. SIGNATURE W.F. Warrender M.D.					
22b. DATE 18 March 1962					
22c. PHYSICIAN'S NAME (Type) W.F. WARRENDER					
22d. ADDRESS U.S. NAVAL HOSPITAL, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 21, 1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town or county) Arlington, Virginia		23e. (State) Virginia		23f. (Country) USA	
24. FUNERAL DIRECTOR'S SIGNATURE JOSEPH GAWLER'S SONS INC. 1756 Pennsylvania Ave					
25a. REC'D BY REGISTRAR DATE MAR 20 '62					
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

00000

00000

M

(MAY)

U. S. MARINE CORPS

Benjamin

Chapman

United Naval Station

Joseph W. Taylor

Yes

Handwritten signature

1:30 P.M.

11:00 P.M.

U. S. MARINE CORPS

U. S. MARINE CORPS

11:00 P.M.

11:00 P.M.

11:00 P.M.

JOSEPH W. TAYLOR, INC. 1750 Pennsylvania Ave.

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician. TO FURNISH TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03387

CERTIFICATE OF DEATH

03380

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) e. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9916 Old Spring Road		d. STREET ADDRESS 9916 Old Spring Road	
3. NAME OF DECEASED (Type or print) Madeline G DRISCOLL		4. DATE OF DEATH March 5, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1885
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Peter P. Spiells	
14. MOTHER'S MAIDEN NAME (Unknown) Lyman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Henry Campbell-daughter-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Unknown DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 5 MIN Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from 5/12 1958 to 3/5 1962 , that (I) (we) last saw the deceased alive on 4 March 1962 , and that death occurred at 4:19 PM from the causes and on the date stated above.			
22. SIGNATURE George Sharpe M.D.		22b. DATE SIGNED 3/5/62	
22c. PHYSICIAN'S NAME (Type) George Sharpe		22d. ADDRESS 10511 Summit Ave., Kensington, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial-Transit	3/8/62	Morris Hill Cemetery	Boise, Idaho
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25. REC'D BY REGISTRAR DATE MAR 9 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Traus	

(M)

(I)

12387

03380

Montgomery

Maryland

Montgomery

Washington

Washington

Wife die Spring Road

Wife die Spring Road

Mansfield

March 2, 63

Female Voice

Nov. 20, 1963

Woman's

Woman's

Female Voice

(Johnston) (Lynn)

Notes

No

George George

1961 Summit Ave., Washington

Robert A. Humphrey, Bethesda, Maryland

Robert A. Humphrey, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03388

CERTIFICATE OF DEATH

Reg. Dist. No.

03381

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1304 Dale Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First REGINA Middle M. Last DUGAN		4. DATE OF DEATH Month March Day 12 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1906
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Id.	
11. BIRTHPLACE (State or foreign country) Id.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Graebenstein		14. MOTHER'S MAIDEN NAME Anna M. Brady	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. John J. Dugan		Address 1304 Dale Drive, Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic renal insufficiency - one kidney removed - a pyelonephritis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1956 , to 3/12 , 19 62 , that I last saw the deceased alive on 3/12 , 19 62 , and that death occurred at 11:44 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1746 K St. N.W. 3/12/62			
ACTUAL SIGNATURE Edward J. Paccione M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/62	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles J. Paccione		24. REGISTRAR'S SIGNATURE Charles J. Paccione	
ADDRESS 5100 Shiloh Ave. Wash. D.C.		DATE MAR 15 '62	

100

TO HOPEFUL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03389

03382

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 9 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5721 Grosvenor Lane Resmor San & Hosp.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6203-Bannockburn Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Moyle Duncan		4. DATE OF DEATH Month March Day 10 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-25-1889	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Gov't	
11. BIRTHPLACE (County & State, or foreign country) Toronto Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Duncan		14. MOTHER'S MAIDEN NAME Alice Lukes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 227-07-3114	
17. INFORMANT Alice E. Duncan		Address Bethesda, Md. 4705-Bradley Blvd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General sepsis DUE TO Decubital ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cerebral & generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hip fracture, rgt		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 5 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 61 , to Mar , 19 62 , that (I) (we) last saw the deceased alive on 3-9 , 19 62 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Dorothy Gill, M.D.		22b. DATE SIGNED 3/10/62	
22c. PHYSICIAN'S NAME (Type) Dorothy Gill, M.D.		22d. ADDRESS 7511 Arlington Rd, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/10/62	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City, town or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		25a. REC'D BY REGISTRAR 2901 14th Street, N.W. Washington 9, D.C.	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE MAR 12 '62	

(M)

(1)

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

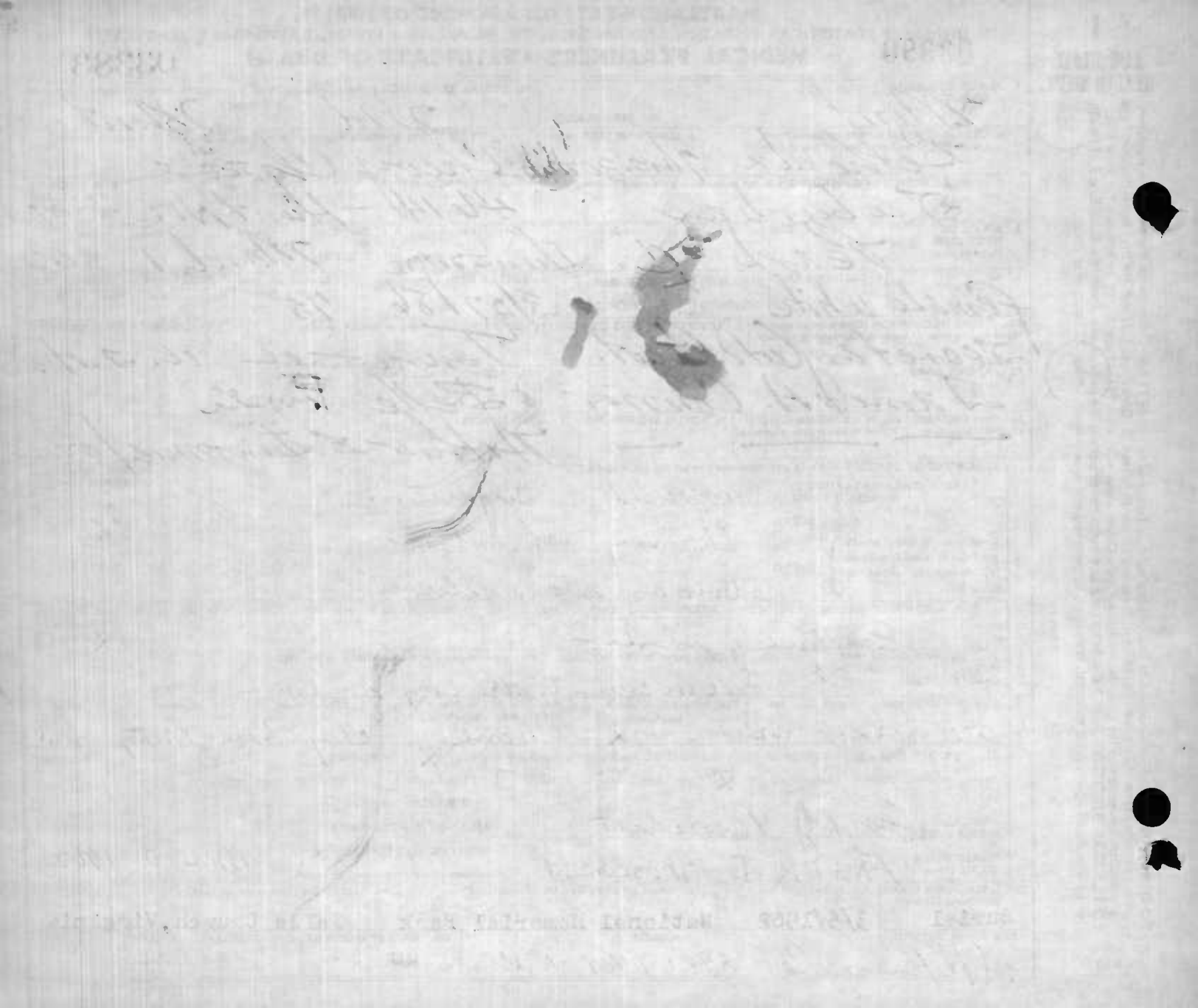
00000

1
FOR STATE
HEALTH DEPT.
M
74
2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any
please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

<div style="display: flex; justify-content: space-between;"> <div> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>03390</p> </div> <div> <p>03383</p> </div> </div> <p>MARYLAND STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p>											
1. PLACE OF DEATH a. COUNTY <u>Mont</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>7 hrs. 30 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>4614 - Hunt Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>C.</u> Last <u>Tunsmore</u>						4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1962</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/27/86</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary (ad) Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tennessee</u>				11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>			
13. FATHER'S NAME <u>James A. Connor</u>						14. MOTHER'S MAIDEN NAME <u>Belle Powell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Arthur E. Tunsmore</u> Address <u>same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary arterio sclerosis</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of skull</u> <u>Fell on concrete driveway at home</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>2:30</u> am <u>—</u> p.m. <u>3-1</u> 1962				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> et work <input type="checkbox"/> et work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Cherry Chase</u> (County) <u>Montg</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>Mar 2-1962</u>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county) <u>Falls Church, Virginia</u>						22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>3/5/1962</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>						22d. LOCATION (City, town, or country) <u>Falls Church, Virginia</u>			22e. ADDRESS <u>2901 14th, N.W.</u>		
23. FUNERAL DIRECTOR <u>S.H. Hines Co.</u>						24a. REC'D BY REGISTRAR <u>5 '62</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur E. Tunsmore</u>		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
03391									
03384									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Silver Spring</u>				
c. LENGTH OF STAY in it <u>12 yrs</u>					d. STREET ADDRESS <u>612 McNeill Rd</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>612 McNeill Rd</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Vincent L. Eaton</u>					4. DATE OF DEATH <u>mar 16 1962</u>				
5. SEX <u>male</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>8-31-15</u>				
9. AGE (in years last birthday) <u>46</u> yrs.					10. IF UNDER 1 YEAR Months Days				
11. IF UNDER 24 HRS. Hours Min.					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Publication office</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Lib. of Congress</u>				
11. BIRTHPLACE (State or foreign country) <u>Venezuela</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
13. FATHER'S NAME <u>Evan W. Eaton</u>					14. MOTHER'S M maiden name <u>Inez Lanus</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Dorothy Eaton (wife)</u>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Barbiturate poisoning</u>					INTERVAL BETWEEN ONSET AND DEATH <u>?</u>				
877.9 DUE TO									
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Frank J. Bruschat</u> M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHAT</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
Address (Street, city, town, or county)					DATE SIGNED <u>3-17-62</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>					22b. DATE THEREOF <u>3-17-62</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>					22d. LOCATION (City, town, or country) (State) <u>Prince George's Co, Maryland</u>				
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> ADDRESS <u>8434 Georgia Ave.</u>					24a. REC'D BY REGISTRAR <u>MAR 20 '62</u>				
Warner E. Pumphrey, Inc. Silver Spring, Maryland					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				

1830

1830



THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03392

03385

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9514 Kentstone Drive				d. STREET ADDRESS 9514 Kentstone Drive			
3. NAME OF DECEASED (Type or print) Mattie Edwards				4. DATE OF DEATH Month March Day 23 Year 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 31, 1887	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-US Govt		11. BIRTHPLACE (County & State, or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred C. Horner				14. MOTHER'S MAIDEN NAME Barbars MacKenzie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT William Byrns-Cousin- New Hampshire	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC Ca. LUNG; PELVIS AND LIVER DUE TO LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO EPIDERMOID Ca. ABDOMINAL WALL.				INTERVAL BETWEEN ONSET AND DEATH 2 years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB. 1963 to MARCH 23, 1963 , that (I) (the) last saw the deceased alive on MARCH 19, 1962 , and that death occurred at 12:40 p.m. from the causes and on the date stated above.							
22a. SIGNATURE J. Blaine Fitzgerald				22b. DATE SIGNED 3-23-62		22c. PHYSICIAN'S NAME (Type) J. Blaine Fitzgerald	
22d. ADDRESS 8218 WISCONSIN AVE. BETHESDA.				22e. REC'D BY REGISTRAR WAR 2 7 '62			
22f. REGISTRAR'S SIGNATURE Robert A. Pumphrey				22g. REGISTRAR'S SIGNATURE Robert A. Pumphrey			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/26/62			
23c. NAME OF CEMETERY OR CREMATORY Wash. Nat. Cemetery				23d. LOCATION (City, town or county) (State) Washington, D. C.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. ADDRESS Bethesda, Maryland			

M

1

03382

03382

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

10/10/1944

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 44 Bethesda	
f. STREET ADDRESS 5329 Pooks Hill Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alan Middle E. Last Evelyn		4. DATE OF DEATH Month March Day 3 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/86
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 10 Days 18 Hours 6 Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		12. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
13. FATHER'S NAME John Evelyn		14. MOTHER'S MAIDEN NAME Mary New	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		16. SOCIAL SECURITY NO. Yes-Unknown	
17. INFORMANT Same as above. Rose Evelyn, Wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombophlebitis of RT. Arm & EMBOLI TO BRAIN & LUNG DUE TO 20001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RADIATION FIBROSIS OF AXILLA & LYMPHADENOMA OF RT. ARM DUE TO 6 years (c) LYPHOSARCOMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 days 18 Month 6 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1949 to MARCH 3 , 19 62 , that (I) (we) last saw the deceased alive on MARCH 2 , 19 62 , and that death occurred at 8:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE William Frank		22b. DATE SIGNED 3/3/62	
22c. PHYSICIAN'S NAME (Type) WILLIAM FRANK, M.D.		22d. ADDRESS 544 W. MONTGOMERY ROCKVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/62	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 7 '62	
25b. REGISTRAR'S SIGNATURE William S. Thomas			

07303



07303

Robert A. Thompson, Bethesda, Maryland

3/10/52

Patricia Cemetery

Rockville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

14
M
50
I
2

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03394

CERTIFICATE OF DEATH

03387

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 19 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 4738 Homer Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Agnes Ezzell		4. DATE OF DEATH March 24 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1885
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Flinn		14. MOTHER'S MAIDEN NAME Rose Lee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mycosis fungoides	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 7 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from March 5 1962 to March 24 1962 that I (we) last saw the deceased alive on March 24 1962 , and that death occurred at 2:35 PM , from the causes end on the date stated above.			
22a. SIGNATURE Geo. H. Porter M.D.		22b. DATE SIGNED March 24, 1962	
22c. PHYSICIAN'S NAME (Type) George H. Porter III, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial March 27-62 - Cedar Hill	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Suitland, Maryland	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros 1661-44 Howard Washington D.C.		25a. REC'D BY REGISTRAR MAR 27 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

(M)

(I)

Female
Housewife
William Flinn
No

born
December 12, 1885
U.S.A.
New Jersey
Horse
Cerebrovascular accident
7 days

19 days
Gutland
1938 Lower Avenue
Bristol
March 2, 1952
The Clinical Center, Bethesda, Md.
Investigator of Health, Bethesda, Md.

George H. Fox

March 2, 1952
March 2, 1952
March 2, 1952

March 2, 1952
March 2, 1952
March 2, 1952

March 2, 1952
March 2, 1952
March 2, 1952

CERTIFICATE OF DEATH

Reg. Dist. No. 03388

03395

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) METHEASTARY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 31			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BEL PRE NURSING HOME				d. STREET ADDRESS 309 DENNIS AVE			
3. NAME OF DECEASED (Type or print) First Middle Last Bertha Feldesman				4. DATE OF DEATH Month Day Year 3 30 1962			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883 APRIL 15, 1883	9. AGE (In years lost birth day) 78 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H W			10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) ROMANIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JACOB SMILOWITZ				14. MOTHER'S MAIDEN NAME RACHEL BERESOV			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				INFORMANT Address 309 DENNIS AVE DR JACKSON FELDESMAN SON			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 3-2-2X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 1 week 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1947 , 19 — , to 3/30 , 19 62 . That I last saw the deceased alive on 3/29 , 19 62 , and that death occurred at 4:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Irving W. Winik				ADDRESS (Street, city or town, state) 3900 McKinley St. N.W.			
PHYSICIAN'S NAME (Type) Irving W. Winik				DATE SIGNED 3/30/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) APRIL 11, 1962				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY MTLEBAND CEMETERY	
23. FUNERAL DIRECTOR'S SIGNATURE B. Kanger...				ADDRESS 3501-14 ST. N.W.		22d. LOCATION (City, town, or county) (State) QUEENS N.Y.	
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE		DATE APR 3 '62	

TO HO... ENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03396 CERTIFICATE OF DEATH 03389

1. PLACE OF DEATH a. COUNTY MONTGOMERY. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 800 MIDLAND ROAD		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 SILVER SPRING d. STREET ADDRESS 800 MIDLAND ROAD a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SUSAN MURPHY FERGUSON First Middle Last		4. DATE OF DEATH Mar 15 1962 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1902. Month Day Year
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOMER	
11. BIRTHPLACE (County & State, or foreign country) GOLDSBORO N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE MURPHEY		14. MOTHER'S MAIDEN NAME ANNIE PATRICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 512 586 MD.	
17. INFORMANT Mrs. ROBERT G. HIRES, 800 MIDLAND RD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH 2 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 23 Dec 1961 to 15 Nov 1962 , that (I) (we) last saw the deceased alive on 12 Nov 1962 , and that death occurred at 7 AM , from the causes and on the date stated above.			
22a. SIGNATURE H. B. Queen		22b. DATE SIGNED 15 Nov 1962	
22c. PHYSICIAN'S NAME (Type) H. B. Queen		22d. ADDRESS 7112 Willow Ave Takoma Park Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAR 17, 1962	
23c. NAME OF CEMETERY OR CREMATORY WILLOW DALE CEM.		23d. LOCATION (City, town or county) (State) GOLDSBORO N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		25a. REC'D BY REGISTRAR Mar 16 '62	
ADDRESS 254 CARROLL ST NW		25b. REGISTRAR'S SIGNATURE	

(M)

(1)

03388

03388

George Murray
Homer
2121 Spring
2121 Spring

2121 Spring
2121 Spring

and

Montgomery

W

Oct 23 1923

George Murray
Homer

Can Home, Greenville N.C.

June Patrick

My Robert Child, Greenville N.C.

Robert Child, Greenville N.C.
My Robert Child, Greenville N.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03397

03390

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 1/2 hours		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS Route 3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sally M. Fitzell				4. DATE OF DEATH March 19, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/1/23	
9. AGE (In years last birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Stewart				14. MOTHER'S MAIDEN NAME Mary Garrison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Walter C. Fitzell / As Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respirator failure 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Metastases DUE TO (c) Carcinoma of the Pancreas				INTERVAL BETWEEN ONSET AND DEATH 1 mo 8 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1962 to March 19, 1962 , that (I) (we) last saw the deceased alive on March 19, 1962 , and that death occurred at 4:57 P.M. from the causes and on the date stated above.							
22a. SIGNATURE William H. Killay				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/19/62	
22c. PHYSICIAN'S NAME (Type) William H. Killay				22d. ADDRESS 8214 Wisconsin Ave Bethesda			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/22/62		23c. NAME OF CEMETERY OR CREMATORY St. John Church Cem.		23d. LOCATION (City, town or county) (State) Kingsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE MAR 22 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House	

08380

08380



Handwritten text, possibly a signature or address, written in cursive script.

Handwritten text, possibly a signature or address, written in cursive script.

Robert A. Thompson, Bethesda, Maryland
St. John Church, Annapolis, Maryland

TO HOSTEL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03398
03399

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>21</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1816 Patton Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Silver Spring</u> d. STREET ADDRESS <u>1816 Patton Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>L</u> Last <u>Fleming</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1962</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1894</u>	9. AGE (In years last birthday) <u>67</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired-So. R. R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William H. Wright</u>			14. MOTHER'S MAIDEN NAME <u>Emma Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give year or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Florence F. Crawford</u>		Address <u>816 Patton Dr.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma rectosigmoid with metastases</u> DUE TO (b) <u>To liver, lungs & brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>
21. I certify that (1) (this hospital) attended the deceased from <u>July</u> , 19 <u>59</u> to <u>March 1</u> , 19 <u>62</u> that (1) (we) last saw the deceased alive on <u>March 1</u> , 19 <u>62</u> , and that death occurred at <u>1055 A.M.</u> from the causes and on the date stated above.						
22a. SIGNATURE <u>James R. Goalson</u>		M.D. <u> </u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u> </u>
22c. PHYSICIAN'S NAME (Type) <u>James R. Goalson</u>		22d. ADDRESS <u>1746 K ST N.W. Washington D.C.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-5-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		ADDRESS <u>4812 Ga. Ave., N.W., Wash. DC</u>		25a. REC'D BY REGISTRAR <u>MAR 8 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

100000

100000

100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03399 CERTIFICATE OF DEATH 03392

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 20 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Delaware b. COUNTY Wilmington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 118 Ruth Street d. STREET ADDRESS 118 Ruth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Evelyn (None) Ford		4. DATE OF DEATH Month March Day 2 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 10, 1901
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria worker		10b. KIND OF BUSINESS OR INDUSTRY Cafeteria	
11. BIRTHPLACE (Country & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James R. Lockerman		14. MOTHER'S MAIDEN NAME Mary Hadley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 221-12-6401	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mycosis fungoides DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO 20 5X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 10, 1962 , to March 2, 1962 that (I) (we) last saw the deceased alive on March 2, 1962 , and that death occurred at 3:00 PM from the causes and on the date stated above.			
22a. SIGNATURE Geo. H. Porter, III M.D.		22b. DATE SIGNED 3/2/62	
22c. PHYSICIAN'S NAME (Type) George H. Porter, III, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-6-62	
23c. NAME OF CEMETERY OR CREMATORY Silver Brook		23d. LOCATION (City, town or county) (State) Wilmington Del.	
24. FUNERAL DIRECTOR'S SIGNATURE Real Funeral Home Wash. D.C.		25a. REGISTRY REGISTRAR 8 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

00330

00330

(M)

Long 007
Booth
The Criminal Center, Toronto 11, Ont.
The Criminal Center, Toronto 11, Ont.

Booth
The Criminal Center, Toronto 11, Ont.
Booth
The Criminal Center, Toronto 11, Ont.

Booth
The Criminal Center, Toronto 11, Ont.
Booth
The Criminal Center, Toronto 11, Ont.

X

Booth
The Criminal Center, Toronto 11, Ont.
Booth
The Criminal Center, Toronto 11, Ont.
Booth
The Criminal Center, Toronto 11, Ont.
Booth
The Criminal Center, Toronto 11, Ont.

TO VITAL ATTENDING PHYSICIAN: The law requires that the death certificate be examined in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

50

1

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03400					03393					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)					
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY			
Montgomery		Bethesda			Maryland		Montgomery			
c. LENGTH OF STAY in 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS			
1 day		The Clinical Center, Bethesda 14, Md.			Rockville 09		1218 Rockville Pike			
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
First Middle Last					Month Day Year					
Forrest (No middle Name) Ford, Jr.					March 29		19 62			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Male		White				3 March 1899		63 yrs.		
10a. USUAL OCCUPATION (Give kind of work during working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Industrial Equipment Operator					Fed. Government		Kentucky		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Forrest Ford, Sr.					Dora Graham					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address			
No					Not available		The Medical Record			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					INTERVAL BETWEEN ONSET AND DEATH					
4-20-0 DUE TO Cardiac arrest										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) Arteriosclerotic heart disease with coronary occlusion					
DUE TO					undetermined					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19										
21. I certify that (X) (this hospital) attended the deceased from March 29, 1962 to March 29, 1962, that (X) (we) last saw the deceased alive on March 29, 1962, and that death occurred at 8:15 A.M. from the causes and on the date stated above.										
22a. SIGNATURE					22b. DATE SIGNED					
David Horwitz M.D.					3/29/62					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
David Horwitz, M.D.					The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)				
Burial-Transit		4/2/62		Memorial Park		Dayton, Ohio				
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey, Bethesda, Maryland					APR 2 '62		Arthur L. Kraus			

VR A15 (4)
15M 9/60



1.

C.V.

On this date, the following information was received from the

Personnel Division, Department of Defense, Washington, D.C.

Re: [Name redacted] [Address redacted]

I am in receipt of the above information and am forwarding it to you for your information.

Very truly yours,

David L. [Name redacted]

Special Agent in Charge

Enclosed for the Office of the Director, Federal Bureau of Investigation, are two copies of the report of the [Name redacted] dated [Date redacted].

Very truly yours,

Enclosed for the Bureau are two copies of the report of the [Name redacted] dated [Date redacted].

x

3/2/52

Enclosed for the Bureau are two copies of the report of the [Name redacted] dated [Date redacted].

Very truly yours,

David L. [Name redacted]

Enclosed for the Bureau are two copies of the report of the [Name redacted] dated [Date redacted].

Robert A. Humphrey, Bethesda, Maryland

1
FOR STATE
HEALTH DEPT.

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any body is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03394

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b <u>30 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>24 Silver Springs</u> d. STREET ADDRESS <u>1824 Violet Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Merl</u> Last <u>Foster</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-14-1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Foster</u>		14. MOTHER'S MAIDEN NAME <u>Annmanda Tarr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Elsie M. Foster, (same as #2)</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Mar 8 1962</u>	
Address (Street, city, town, or county) <u> </u>		22a. LOCATION (City, town, or country) <u> </u>	
22b. DATE THEREOF <u>March 12, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u>	
22d. LOCATION (City, town, or country) <u>Prince Georges County, Maryland</u>		23. FUNERAL DIRECTOR <u>Arthur Walters</u>	
ADDRESS <u>254 Carroll St. N.W. - Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	
DATE <u>MAR 12 '62</u>			



Washington, D.C.

February 10, 1904

My dear Mr. [Name]

I have just received your letter of the 8th inst.

and am glad to hear that you are

interested in the [Subject]

and that you are planning to visit

the [Location] in the near future.

I am sure that you will find it very

interesting.

I am, Sir, very

truly yours,

[Signature]

[Name]

[Title]

[Institution]

[Address]

[City]

Very truly yours,

[Signature]

[Name]

[Title]

[Institution]

[Address]

[City]

[State]

[Country]

10000

10000

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03402
CERTIFICATE OF DEATH
03395

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia		b. COUNTY			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital		e. STREET ADDRESS 603 Ferry Landing Rd.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Winfield Stover FRANCIS		4. DATE OF DEATH Month Day Year March 17 1962									
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-22-33		9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Henry Watson Stover		14. MOTHER'S MAIDEN NAME Dorothy Armstrong									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT HUS: Evans J. Francis		Address Same As #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcoma, unclassified DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (X) (this hospital) attended the deceased from March 13, 1962 to March 17, 1962, that (X) (we) last saw the deceased alive on March 17, 1962, and that death occurred at 12:45 AM, from the causes and on the date stated above.											
22a. SIGNATURE Benjamin J. Gilson		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 17 March 1962	
22c. PHYSICIAN NAME (Type) Benjamin J. Gilson, LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-20-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National Alexandria, Virginia		23d. LOCATION (City, town or county) Arlington, Virginia		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Everly-Wheatley Funeral Home, 1500 W. Braddock Rd.		25a. REC'D BY REGISTRAR DATE MAR 20 '62		25b. REGISTRAR'S SIGNATURE Curtis S. House							

(M)

03132

03132

CERTIFICATE OF DEATH

INFORMANT

REPORT

DATE OF DEATH

PLACE OF DEATH

10:15 AM

10:15 AM

17

10:15 AM

10:15 AM

10:15 AM

10:15 AM

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03403

CERTIFICATE OF DEATH

03396

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHEATON c. LENGTH OF STAY IN b. 30 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BELPRE Nursing + Conv. Home, Inc				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 07 Gaithersburg, Md. d. STREET ADDRESS 10 WALKER AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) WILLIAM P. FRANK		4. DATE OF DEATH 3 24 1962		5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Gen. Construction				11. BIRTHPLACE (County & State, or foreign country) 01110				12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. unknown				17. INFORMANT Fannie E. Frank Address Same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis DUE TO (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema												INTERVAL BETWEEN ONSET AND DEATH 1 week Several years Several years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from 1/27/62 , 19 62 , to 3/23 , 19 62 , that (I) (we) last saw the deceased alive on 3/23 , 19 62 , and that death occurred at 245 AM , from the causes and on the date stated above.																			
22a. SIGNATURE Max G. Sherer MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 3/24/62											
22c. PHYSICIAN'S NAME (Type) MAX G. SHERER, MD				22d. ADDRESS 2025 EAST West H'way Silver Spring Md															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 27 1961		23c. NAME OF CEMETERY OR CREMATORY Laytonsville				23d. LOCATION (City, town or county) Laytonsville Md.											
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.				25a. REC'D BY REGISTRAR MAR 28 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Frank							

M

03403

STATE OF OHIO

03388

Hamilton

Newton

Bellevue Nursing Home

William

Frank

Male - White

U.S. 1962

Coroner's Office

Ohio

Unknown

Unknown

To

Unknown

Frank

Page 2

Hamilton, Ohio

Hamilton, Ohio

Hamilton, Ohio

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death, and retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03404

03397

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3		
c. LENGTH OF STAY IN 1b			d. STREET ADDRESS <u>4500 CONN. AVE. N.W.</u>		
NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DEL PEE NURSING HOME</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>PHILIP</u> First Middle Last			4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1962</u>		
5. SEX <u>M</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>JULY-31-1902</u> 59 yrs.		
9. AGE (In years last birthday)			IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JEWELEER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>LONDON, ENGLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>MAX FRANKS</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>577-40-7466</u>		
17. INFORMANT <u>LILY FRANKS</u>			Address <u>4500 CONN. AVE. N.W.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>163 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u>CEREBRAL Metastases</u> DUE TO (c) <u>CANCER of the Lung</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>1 year</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Metastatic Disease to other portions of Lungs</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>December 28, 1961</u> to <u>March 7, 1962</u> , that (I) (we) last saw the deceased alive on <u>MARCH 7, 1962</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Max G. Sherer</u> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3/7/62</u>		
22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER MD</u>			22d. ADDRESS <u>2021 Eye Street NW Washington, D.C.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3/11/62</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>			23d. LOCATION (City, town or county) (State) <u>FALLS CHURCH, VA.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. [unclear]</u>			25a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>		
ADDRESS <u>4217-9th St NW</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur L. [unclear]</u>		

032215

03100

M

04149

we know

Mr. [unclear]

Office of the [unclear]

What then [unclear]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03405
CERTIFICATE OF DEATH
03398

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 34 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Virginia b. COUNTY Edinburg c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route #2, Box 66 d. STREET ADDRESS 83x-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ronald Pennywitt Funkhouser		4. DATE OF DEATH Month March Day 7 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 19, 1940
9. AGE (In years last birthday) 21 yrs.		10. IF UNDER 1 YEAR Months 4 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		12b. KIND OF BUSINESS OR INDUSTRY Not employed	
13. FATHER'S NAME S. Alvin Funkhouser		14. MOTHER'S MAIDEN NAME Louise Kagey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terato-choriocarcinoma of left testis with DUE TO carcinomatosis. Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 4 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 1, 1962 to March 7, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 7, 1962 , and that death occurred at 5:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Geo. H. Porter III M.D.		22b. DATE SIGNED 3-6-62	
22c. PHYSICIAN'S NAME (Type) George H. Porter, III, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-10-62	23c. NAME OF CEMETERY OR CREMATORY Bethel	23d. LOCATION (City, town or county) (State) Edinburg Va.
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home Washington D.C.		25a. REC'D BY REGISTRAR MAR 9 '62 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Finner	

03332

OFFICE OF THE

13402

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

1940

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 256, Film G309 3/29/62 iwk Item 8 Film G310 3/29/62 iwk											
03406 03399											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Virginia b. COUNTY Portsmouth					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Portsmouth					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						d. STREET ADDRESS 918 North Street					
3. NAME OF DECEASED (Type or print) Eugene Franklin Gayle Jr.						4. DATE OF DEATH Month Day Year March 23, 1962 19					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1941		9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days March 23, 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Man				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene F. Gayle						14. MOTHER'S MAIDEN NAME Ruth E. Swain					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes No				16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of testis with metastases 178X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 8, 1962 to March 23, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 23, 1962 , and that death occurred at 10:37 AM the causes and on the date stated above.											
22a. SIGNATURE R. T. Brooks Jr. M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> March 23, 1962					
22c. PHYSICIAN'S NAME (Type) R. T. BROOKS LT MC USN						22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Mar. 24, 1962		23c. NAME OF CEMETERY OR CREMATORY Hampton National		23d. LOCATION (City, town or county) Hampton, Virginia		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. W. W. CHAMBERS Funeral Home, 1400 Chapin St., WDC						25a. REC'D BY REGISTRAR MAR 27 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

(M)

1403

03339

U. S. Naval Hospital
Bethesda (Bldg.)
Baltimore, Md.
Virginia
March 23, 1946
R. T. BROOKS LT MC USN
R. T. BROOKS LT MC USN
U. S. Naval Hospital, Bethesda, Md.
Virginia
March 23, 1946

W. W. CHAMBERS Personal Home, 1400 Chapin St., WDC
Hampden National
Hampden National
U. S. Naval Hospital, Bethesda, Md.
Virginia
March 23, 1946

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 03400? Item 8 Film G308 3/12/62 iwk 03400													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 hrs. 15 min.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Asbury</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>E. Gelman</u> Last <u>of</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1962</u>									
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/19/1879</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penney's</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Lowery</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Rhodes</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Francis Porter Townsend, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (this hospital) attended the deceased from <u>MAR. 4, 1962</u> to <u>MAR. 4, 1962</u> , that (we) last saw the deceased alive on <u>MAR. 4, 1962</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>Robert G. Angle, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>3-4-62</u>					
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>				22d. ADDRESS <u>50090 Delray Ave. Bethesda. Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-7-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sandy Mount Church</u>				23d. LOCATION (City, town or county) (State) <u>Sandy Mount Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Porter</u>				ADDRESS <u>316 E. Diamond Ave. Gaithersburg, Md.</u>				25e. REC'D BY REGISTRAR <u>MAR 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Thomas</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b. <u>8 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11416 Sherrie Lane</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Silver Spring</u> d. STREET ADDRESS <u>11416 Sherrie Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Marion Graceon Gibson Jr.</u> First Middle Last				4. DATE OF DEATH <u>Mar 11 1962</u> Month Day Year											
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-9-25</u>		9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam fitter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>John Fitzgerald Co.</u>				11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U-S-A.</u>			
13. FATHER'S NAME <u>Marion G. Gibson Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Gass</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WWII</u>				16. SOCIAL SECURITY NO. <u>220-16-4568</u>				17. INFORMANT <u>Gibson</u> Address <u>Barbara Gibson (wife) Elm 2</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>3-11-62</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-14-62</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Suitland Prince George's Co., Md.</u>			
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> <u>8434 Georgia Ave</u> <u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Maryland</u>								24a. REC'D BY REGISTRAR <u>MAR 15 '62</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

10480

1
Page 4
To Hospital or Funeral Home: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
03409
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03402

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens San.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. STREET ADDRESS 5524 9th Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martin Middle George Last Gilbertson		4. DATE OF DEATH Month Mar Day 21 Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/82
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.Mgr. Kennedy-Warren Garage		10b. KIND OF BUSINESS OR INDUSTRY Norway	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Gilbertson		14. MOTHER'S MAIDEN NAME Augusta	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no If yes, give war or dates of service		16. SOCIAL SECURITY NO. 578-05-5687	
17. INFORMANT Mrs. Lucille Dennison		Address Wash, D.C. 5524 9th St. N.W.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4201 DUE TO acute Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertensive arteriosclerotic cardiovascular dis. DUE TO 6 yrs		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 29 19 62 to Mar 21 19 62 , that (I) (we) last saw the deceased alive on Mar 20 19 62 , and that death occurred at 5:40 P. from the causes and on the date stated above.			
22a. SIGNATURE M.F. Ottman		22b. DATE SIGNED Mar 21, 1962	
22c. PHYSICIAN'S NAME (Type) M.F. OTTMAN MD		22d. ADDRESS 11800 Ga Ave SE 9nd	
23a. BURIAL, CREMATION, REMOVAL (Specify) 3/24/62		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.,		25a. REC'D BY REGISTRAR MAR 22 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

103412

CERTIFICATE OF DEATH

103412

(M)

Montgomery

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

George

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03410

03403

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN b 43 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 DAMASCUS d. STREET ADDRESS 24910 WOODFIELD ROAD e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIOLA L. GILLISS		4. DATE OF DEATH Month Day Year 3-14-62 19	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-75
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days 3 14	
11. IF UNDER 24 HRS. Hours Min. 19		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY GOVT. AGRICULTURAL DEPT.	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN S. GILLISS		14. MOTHER'S MAIDEN NAME HARRIETT LEANAH RICHKETTS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY Emboli, MASSIVE 466X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) PULMONARY INFARCT, MULTIPLE DUE TO (c) THROMBOSIS DEEP FEMORAL VEINS		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 3:15P to March 14, 1962 , that (I) (we) last saw the deceased alive on March 14, 1962 , and that death occurred at 3:15P M, from the causes and on the date stated above.			
22a. SIGNATURE G. F. MEADORS, M.D.		22b. DATE SIGNED 3/16/62	
22c. PHYSICIAN'S NAME (Type) G. F. MEADORS, M.D.		22d. ADDRESS DAMASCUS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF March 18 1962	
23c. NAME OF CEMETERY OR CREMATORY Rockville Union		23d. LOCATION (City, town or county) (State) Rockville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR MAR 20 '62	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. House	

(M)

08410

08410

Special Agent in Charge, Knoxville Union

Knoxville, Tenn.

DAMASCUS, SYRIA

S. F. HADJOS, N.Y.

Residence

Embassy, Damascus
Embassy, Beirut
Embassy, Tripoli

Positive Record

None

No

100% S. F. HADJOS

Positive Record

Retired

100% S. F. HADJOS

Positive Record

100% S. F. HADJOS

Positive Record

100% S. F. HADJOS

Positive Record

100% S. F. HADJOS

Positive Record

100% S. F. HADJOS

100% S. F. HADJOS

100% S. F. HADJOS

100% S. F. HADJOS

100% S. F. HADJOS

TO HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03411

CERTIFICATE OF DEATH

03404

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington c. STREET ADDRESS 3911 Military Rd., N. W. d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY MARGARET GLESSNER		4. DATE OF DEATH Month March , Day 3 , Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 16, 1898
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 11 Days 17 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY U. S.	
13. FATHER'S NAME William D. McFarland		14. MOTHER'S MAIDEN NAME Mary Oulihan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-28-7272	
17. INFORMANT Husband		Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Metastasis carcinoma to bone & brain Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Carcinoma of breast. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 		INTERVAL BETWEEN ONSET AND DEATH 7 days 7 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1939 to March 3, 1962 ; that (I) (we) last saw the deceased alive on March 1, 1962 , and that death occurred at 4:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Gilbert B. Rude		22b. DATE SIGNED March 3, 1962	
22c. PHYSICIAN'S NAME (Type) GILBERT B. RUDE		22d. ADDRESS 3900 Military Rd. N.W. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/62	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) Prince George Co. Md. (State) 	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 7 '62 25b. REGISTRAR'S SIGNATURE Carroll L. Hanna	

VR A15 (4)

15M 7/61

(M)

03011

CENTRAL OF ALASKA

03011

Post Office

District of Columbia

Post Office

Washington

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

03412

03405

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg. Rural</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>08 Gaithersburg. Rural</u>	
c. LENGTH OF STAY in 1b <u>40yr</u>		d. STREET ADDRESS <u>LongDraft Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>Josephine</u> Last <u>Glover</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>24</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 24-1896</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>0</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None Work</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>San Francisco. Calif.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles Burdette</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Shuck</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Henry Musser, Gaithersburg. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EMBOLUS</u> <u>193.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>BRAIN ATROPHY</u> (c) <u>CARCINOMA OF SPINAL CORD</u> DUE TO cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u> <u>ONE YEAR</u> <u>5 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 23, 1961</u> to <u>MARCH 24, 1962</u> , that (I) (we) last saw the deceased alive on <u>MARCH 21, 1962</u> and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rosenberger</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger, M. D.</u>		22d. ADDRESS <u>310 W. Montgomery Ave, Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-27-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>		23d. LOCATION (City, town or county) (State) <u>Rockville. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 27 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

2013

M

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03406									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>mont</u> ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1002 Bruce Rd</u>					d. STREET ADDRESS <u>1002 Bruce Rd</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Ellen Golden</u>					4. DATE OF DEATH Month Day Year <u>mar 4 1962</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-15-62</u>		9. AGE (in years last birthday) <u>0</u> yrs. <u>19</u> Months Days	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Ralph Golden</u>					14. MOTHER'S MAIDEN NAME <u>Jewell Kuntz</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address <u>Ralph Golden (father) Item 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 475X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Upper Respiratory Infection</u> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>24 hrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Brosch</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. BROSCH</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					Address (Street, city, town, or county) <u>3-4-62</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>March 5-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lee Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Washington DC</u>			
23. FUNERAL DIRECTOR <u>Lee Funeral Home</u>					ADDRESS <u>Washington, DC</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kuntz</u>

2147

240525

EPA 20



THE

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03414						03407					
1. PLACE OF DEATH e. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>FLORIDA</u> b. COUNTY <u>OSCEOLA</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>10 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARTLAND, FLORIDA</u>				d. STREET ADDRESS <u>123 HOLLY COURT 48X13</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>VICTOR E. GOODWIN</u>						4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1962</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 11, 1879</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General Electric Corp.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Minneapolis, Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Goodwin</u>						14. MOTHER'S MAIDEN NAME <u>Ann Craik</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>016-03-5301</u>		17. INFORMANT <u>EDNA GOODWIN</u>		Address <u>123 Holly Court</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>AORTIC STENOSIS</u> (c) <u>ARTERIOSCLEROSIS</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>PNEUMONIA, LOBAR</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>		Month, Day, Year <u>1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <u>May</u> , 19 <u>62</u> , to <u>March 11</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>March 11</u> , 19 <u>62</u> , and that death occurred at <u>7:35</u> P.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert F. Dyer M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/14/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. DYER M.D.</u>						22d. ADDRESS <u>915 19th Street NW</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3/14/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>						ADDRESS <u>2901 14th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>MAR 14 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
						DATE					

56420

2:50

(M)

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03415
Items 8 & 9 Film G309 3/15/62 iwk
03408

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4404 Colfax Street		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Kensington d. STREET ADDRESS 4404 Colfax Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mendez		4. DATE OF DEATH March 6 19 62		5. SEX Male	
6. COLOR OR RACE White		7. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 11/20/83 1882	
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR 3 Months 16 Days		11. IF UNDER 24 HRS. 79 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Salesman		10b. KIND OF BUSINESS OR INDUSTRY Selling		11. BIRTHPLACE (County & State, or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Julius Gottschalk		14. MOTHER'S MAIDEN NAME Marie Rammenstein	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 057-16-8244		17. INFORMANT Helen Ellen E. Gottschalk Melen E. Gottschalk - Wife-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 ARTERIOSCLEROTIC CARDIOVASCULAR DIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH years.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from Oct. 9, 1956 to MAR. 6, 1962 , that (I) (we) last saw the deceased alive on MAR. 5, 1962 , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE DeWitt E. DeLawter		22b. DATE SIGNED 3-6-62		22c. PHYSICIAN'S NAME (Type) DeWitt E. DeLawter	
22d. ADDRESS 3848 Porter Street, N. W., Wash. DC		23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial			
23b. DATE THEREOF 3/8/62		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR WAR 9 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



03218

03108

Montgomery

Maryland

Montgomery

Washington

Washington

4404 Colfax Street

4404 Colfax Street

Member

Constitution

Member

John H. Hines

John H. Hines

Reg. Salesman

Selling

New York

John H. Hines

John H. Hines

no

937-1-8204

937-1-8204

David E. DeBart

2848 Porter Street, N.W., Wash. DC

2/2/62

Bartholomew County

Bartholomew County

Robert A. Humphrey, Bethesda, Maryland

Robert A. Humphrey, Bethesda, Maryland

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXERCISED WITHIN 24 HOURS AFTER DEATH.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN b. 26 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7607 Eastern Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 25 Takoma Park, Maryland d. STREET ADDRESS 7607 Eastern Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Phillip Henry Goundie		4. DATE OF DEATH March 26 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Floor Manager Hecht Company		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Goundie		14. MOTHER'S MAIDEN NAME Mary V. Petty	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-10-3101	
17. INFORMANT Mrs. Iola C.V. Case		Address Takoma Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 442X DUE TO nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Congestive Heart Failure			
INTERVAL BETWEEN ONSET AND DEATH 1 wk. 1 yr. 10 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 3/25 1960 to 3/25 1962 , that (I) (we) last saw the deceased alive on 3/25 1962 and that death occurred 3:00 AM , from the causes and on the date stated above.			
22a. SIGNATURE Raymond J. Randall M.D.		22b. DATE SIGNED 3/26/62	
22c. PHYSICIAN'S NAME (Type) S. J. RANDALL, M.D.		22d. ADDRESS 3636 16 ST. N.W. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-62	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince George's Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR Arthur S. House	
25b. REGISTRAR'S SIGNATURE		DATE MAR 30 '62	

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

112109

03417

CERTIFICATE OF DEATH

Reg. Dist. No. 03410

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6609 Brookville Road		d. STREET ADDRESS 6609 Brookville Road	
3. NAME OF DECEASED (Type or print) First HARVEY Middle BEECHER Last GRAM		4. DATE OF DEATH Month MAR. Day 26 Year 1962	
5. SEX MALE	6. COLOR OR RACE CAU.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 24, 1869
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. War Dept.	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Gram		14. MOTHER'S MAIDEN NAME Margaret Dell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Harvey B. Gram, Jr.		Address 5804 Overlea Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic brain syndrome Washington 16, D. C. 332X DUE TO Cerebro-vascular Thrombosis 5 MONS. Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO Cerebral Arteriosclerosis 6 MONS. (c) UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from AUG 18, 1961 to MAR 26, 1962 that I last saw the deceased alive on MAR 26, 1962 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert S. Poole		ADDRESS (Street, city or town, state) 4501 CONN AVE	
PHYSICIAN'S NAME (Type) ROBERT S. POOLE, M.D.		DATE SIGNED 3/26/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-29-1962	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Gorman		24. REC'D BY REGISTRAR DATE MAR 29 '62	
ADDRESS 1756 Palmdale		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1947

CERTIFICATE OF DEATH

(C)

1947

State of Ohio, County of Hamilton, City of Dayton.
I, the undersigned, being a duly qualified physician, do hereby certify that

on the 10th day of May, 1947, at Dayton, Ohio, died

of the disease of

Heart Disease, of the nature of

Coronary Artery Disease, which was caused by

arteriosclerosis, a natural cause, and not due to

any other cause, and that the death was not due to

any other cause, and that the death was not due to

any other cause, and that the death was not due to

any other cause, and that the death was not due to

any other cause, and that the death was not due to

any other cause, and that the death was not due to

any other cause, and that the death was not due to

any other cause, and that the death was not due to

any other cause, and that the death was not due to

any other cause, and that the death was not due to

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03411

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY in 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>515 Quintana Place N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ausie E Duffen</u>		4. DATE OF DEATH <u>March 19 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Madison, Va.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin F Turner</u>		14. MOTHER'S MAIDEN NAME <u>Ella Sullivan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Dorothy E. Watson</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Bilateral</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Congestive Heart Failure</u> (c) <u>Hypertensive & Arteriosclerotic Heart Disease</u> cause last. <u>4 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>7 days</u> <u>4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb-28</u> to <u>March 17</u> , 19 <u>62</u> that (I) <u>we</u> last saw the deceased alive on <u>March 18</u> , 19 <u>62</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Horace H. Custis Jr.</u>		22b. DATE SIGNED <u>3/19/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Horace H. Custis, Jr.</u>		22d. ADDRESS <u>1852 Columbia Rd., N.W., Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3/22/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 21 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

08411



LORANCE H. GASTIN, JR.

1525 Columbia Rd., N.W., Washington, D.C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

FOR STATE
HEALTH DEPT.

1. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY COUNTY, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>montg</u> P.G. <u>✓</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>				c. LENGTH OF STAY IN lb <u>2 yrs</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Potomac Manor Rest Home</u>				d. STREET ADDRESS <u>5451 Newton St. Apt. 10</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Arne D.</u> Middle <u>Grigory</u> Last <u>Rest Home</u>				4. DATE OF DEATH Month <u>mar</u> Day <u>8</u> Year <u>1962</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-21-1874</u>		9. AGE (In years last birthday) <u>87</u>		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rest Home</u>				11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Alfred Askew</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Rest Home Record</u>				17. INFORMANT Address <u>Rest Home Record</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>month</u>												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia 2 wks ago</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Frank J. Brosechant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-8-62</u>					
EXAMINER'S NAME (Type) <u>FRANK J. Brosechant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Mar. 12-62</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>					
22d. LOCATION (City, town, or country) <u>Richmond Va.</u>				22e. ADDRESS <u>1661- Good Hope Rd. S.E. WASHINGTON D.C.</u>				22f. REC'D BY REGISTRAR <u>DATE MAR 12 '62</u>					
23. FUNERAL DIRECTOR <u>SIMMONS BROS.</u>				24a. REGISTRAR'S SIGNATURE <u>William S. Flowers</u>				24b. REGISTRAR'S SIGNATURE					

00110

00110

(M)

(M)

(M)

(M)

(M)

(M)

(M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other action is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

M

74

I

2

2

03420

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03413

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>3908 Morrison St.,</u>			
3. NAME OF DECEASED (Type or print) <u>Larry T. Gurley</u>				4. DATE OF DEATH <u>March 14, 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>FEB 24, 1896</u>	
9. AGE (in years, last full day) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (ret.)</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>I</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>526 07 6928</u>			
17. INFORMANT <u>Charles G. Quinn</u>				Address <u>118-2nd St. Greenwood Acres, Annapolis, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gangrene of intestinal tract</u> 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>mesenteric thrombosis</u> 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. Frank Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-19-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR <u>W-W Chambers Co.</u>				24a. REC'D BY REGISTRAR <u>Mar 19 '62</u>			
ADDRESS <u>5801 Cleveland Ave</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

00113

00113

(M)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "L. L. L." and "L. L. L." are visible.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03421
CERTIFICATE OF DEATH
03414

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in 1b 5 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Bethesda			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban				d. STREET ADDRESS 1 5073 River Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lewis M. Hall				4. DATE OF DEATH Month Day Year March 22, 1962			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/29		9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan Hall				14. MOTHER'S MAIDEN NAME Rachael Thompson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 218-20-1697		17. INFORMANT wife		Address same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoidal hemorrhage, right DUE TO Conditions, if any, which gave rise to immediate cause (b) Ruptured cerebral aneurysm, middle cerebral artery, right (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 330X						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 16, 1962 to March 22, 1962 ; that (I) (we) last saw the deceased alive on Mar. 21, 1962 , and that death occurred at 2:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE John L. Lord				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. John Lord				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL, etc. Robert L. Snowden		23b. DATE THEREOF 3/25/62		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Church.,		23d. LOCATION (City, town or county) (State) Centerville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden.				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE MAR 27 '62	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

02114

02114

(M)

100

100-100-100

Handwritten signature

100-100-100

100-100-100

100-100-100

100-100-100

100-100-100

1
FOR STATE
HEALTH DEPT.

is necessary, if any, to the funeral director, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

99

0

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03422

03415

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takom Park D.O.A.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San & Hosp</u>				d. STREET ADDRESS <u>19511 Colesville Rd</u>			
3. NAME OF DECEASED (Type or print) <u>William Edgar Hallman</u>				4. DATE OF DEATH <u>3-6-1962</u>			
5. SEX <u>WM</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-8-88</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motion Picture Projectionist</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Martin Hallman</u>				14. MOTHER'S MAIDEN NAME <u>Annie Gardner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-05-0631</u>		17. INFORMANT <u>Mrs. George R. Muschlitz, 104 Franklin Ave., Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>3-7-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 9, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
				22d. LOCATION (City, town, or country) <u>Prince George's County, Md.</u>		(State)	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 9 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

03115

03115

(M)

(1)

817-05-0521 Mrs. George A. Schuchman, 104 Franklin Ave.,
New York 100, N.Y.

Office of the Secretary, U.S. Department of the Interior,
Washington, D.C. 20540

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 1 is retained by the hospital or attending physician. Page 2 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03423

CERTIFICATE OF DEATH

03416

Item 9 Film G310 4/2/62 mh

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda MARYLAND</u> c. LENGTH OF STAY IN 1b <u>30 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmor Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Alexandria, 83X-3</u> d. STREET ADDRESS <u>11 E. Walnut ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD AUGUSTUS HAMILTON</u>				4. DATE OF DEATH Month Day Year <u>MARCH 24 1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 18, 1885</u> 9. AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE BROKER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM HAMILTON</u>				14. MOTHER'S MAIDEN NAME <u>POOLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WWII</u>				16. SOCIAL SECURITY NO. <u>WWI</u>		17. INFORMANT Address <u>JOHN HAMILTON - SON - 144 DS + S.E. GAS43DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic hypertensive heart disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <u>Renal failure due to arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from <u>March 23, 1962</u> to <u>March 24, 1962</u> , that (I) (we) last saw the deceased alive on <u>March 23, 1962</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Michael M. Dobridge</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 25, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Michael Dobridge</u>				22d. ADDRESS <u>10620 Georgia Ave Silver Spring Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/27/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION (City, town or county) (State) <u>ARLINGTON, VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan Inc. 317 Penn. Ave. S.E.</u>				25e. REC'D BY REGISTRAR <u>MAR 27 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

2173

664

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
03424
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03417

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LeDeau Gardens</u>		d. STREET ADDRESS <u>1 2100 Hildarose Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>C.</u> Last <u>Harding</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9, 1883</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Henry Culver</u>		14. MOTHER'S MAIDEN NAME <u>Caroline D. Graf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Kenneth Culver, 7206 Honeywell La., Bethesda, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hyper tension</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>4 yrs</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>June</u> <u>1960</u> to <u>Mar 12</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>Mar 12</u> <u>1962</u> , and that death occurred at <u>9:30 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John Lawrence Avery</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3-12-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>John Lawrence Avery, MD.</u>		22d. ADDRESS <u>10110 Georgia Ave., Silver Spring Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 15, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Colesville, Montgomery Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc., Silver Spring, Md.</u>		25. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>	
DATE <u>MAR 15 1962</u>			

00117

RECEIVED

1954

(M)

Handwritten notes and stamps, mostly illegible due to fading and bleed-through. Some legible fragments include:

- RECEIVED
- 1954
- Handwritten text: "Handwritten notes and stamps, mostly illegible due to fading and bleed-through."

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03425 CERTIFICATE OF DEATH 03418

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u> c. LENGTH OF STAY IN 1b <u>25 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Lillie</u> First <u>May</u> Middle <u>HARVEY</u> Last 4. DATE OF DEATH <u>March</u> Month <u>2</u> Day <u>19</u> Year <u>62</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Wh.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 8, 1874</u> 9. AGE (In years last birthday) <u>87</u> yrs. 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> 11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Cty. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Carlton Edward OLAND</u> 14. MOTHER'S MAIDEN NAME <u>Margaret Ann CRAVER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>none.</u> 17. INFORMANT <u>C. W. Harvey</u> Address <u>Brookeville, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>years</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 2 1962</u> to <u>Mar 2 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar 2 1962</u> , and that death occurred at <u>11:30 P.</u> M, from the causes and on the date stated above.				
22a. SIGNATURE <u>Richard A. Yates MD</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Richard A. YATES</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3/2/62</u> 22d. ADDRESS <u>OLNEY, Md.</u>		
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u> 23b. DATE THEREOF <u>March 5 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u> 23d. LOCATION (City, town or county) (State) <u>Olney Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u> 25a. REC'D BY REGISTRAR <u>6 '62</u> DATE <u>Mar</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

Lawrenceville, Mo.

St. Johns

March 5 1903

Bureau

Robert H. Yates

St. Louis, Mo.

St. Louis, Mo.

St.

St.

St.

St.

St.

St.

St.

St.

St.

St.

St.

St.

St.

St.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03426 03419

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Nursing Home-Kensington		d. STREET ADDRESS North Avenue	
3. NAME OF DECEASED (Type or print) First CLARA Middle Alice Last HAYNIE		4. DATE OF DEATH Month March Day 23 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1874
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Virginia
13. FATHER'S NAME John Haynie		14. MOTHER'S MAIDEN NAME Elizabeth Berry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bessie Johnston-2629 Henderson -Silver Spring		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) ESSENTIAL HYPERTENSION (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN 24 1957 to March 23 1962, that (I) (we) last saw the deceased alive on March 23 1962, and that death occurred at 8:10 AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Benjamin Loudon</i> M.D.		22b. DATE SIGNED March 23 1962	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 5206 Montross Dr Cherry Chase, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/26/62	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>		25a. REC'D BY REGISTRAR MAR 27 '62	
ADDRESS Ellsworth Armacost-4600 Liberty Hgts. Avenue		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

01119

01119



ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. It must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03427
03420

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY in lb 15 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wheaton, Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 DAMASCUS d. STREET ADDRESS 125705 Wright Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle WELSH Last HENDERSON		4. DATE OF DEATH Month MAR Day 31 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 8 - 1899
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WARNER WELSH	
14. MOTHER'S MAIDEN NAME Clara Adams		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Anne Lindsay-Daughter-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) Myocardial failure (b) Arterio Sclerosis + Insufficiency (c) Arteriosclerotic Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension. Debility. Senile Brain Syndrome			
19. INTERVAL BETWEEN ONSET AND DEATH 2 hr. 4 yrs. 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1958 to Mar 31, 1962 , that (I) (we) last saw the deceased alive on Mar 31, 1962 , and that death occurred at 11:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James E. Gannon Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JAMES A. GANNON, JR. M.D.		22d. ADDRESS 3141-34th Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/62	
23c. NAME OF CEMETERY OR CREMATORY Hyattstown Ch. Cem.		23d. LOCATION (City, town or county) (State) Hyattstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR APR 6 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

1520

7530



PPH-4

78-100-1

James A. Cannon June 1-24-47

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03428

CERTIFICATE OF DEATH

03421

Item 23b, Film G309 3/27/62 iwk

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Kentucky b. COUNTY Valley Station			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Valley Station			
c. LENGTH OF STAY IN 1b 9 days				d. STREET ADDRESS 4806 Seville Drive			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lola Middle Faye Last Henning				4. DATE OF DEATH Month March Day 20 Year 19 62			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1955	
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months 6 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jack Hardin Henning				14. MOTHER'S MAIDEN NAME Anna Mildred Drane			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. - - - - -			
17. INFORMANT FATHER: Jack H. Henning, Same as #2				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hemorrhage, gastrointestinal 1977.9 DUE TO rabdomyosarcoma, generalized Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 48 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 10, 1962 to March 20, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 20, 1962 and that death occurred at 10:07 from the causes and on the date stated above.							
22a. SIGNATURE Robert V. Rack M.D.				22b. DATE SIGNED March 20, 1962			
22c. PHYSICIAN'S NAME (Type) ROBERT V. RACK LT MC USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 24, 1962		23c. NAME OF CEMETERY OR CREMATORY Kingswood		23d. LOCATION (City, town or county) (State) Kingswood, Kentucky	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Tyson-Wheeler Funeral Home, Rockville Pike,				25a. REC'D BY REGISTRAR DATE MAR 22 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

7-252

03121

Memorandum

Re: (Name)

U. S. Naval Hospital

John

Memorandum

John

John

John Harris Manning

John Harris Manning

John Harris Manning

Handwritten signature

March 10, 1942

10:00

March 10, 1942

Handwritten signature

March 10, 1942

U. S. Naval Hospital, Bethesda, Md.

Robert V. Pace Jr. USN

Kingwood, Kentucky

Kingwood, Kentucky

Tyson Wheeler, General Home, Roseville, Calif.

TO HOSPITAL
death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03429

CERTIFICATE OF DEATH
Item 1c Film G310 4/2/62 mh

03422

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 Bethesda d. STREET ADDRESS 4612 South Chelsea Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Pearl Ruby Hertz		4. DATE OF DEATH Month Day Year March 19 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 24, 1910
9. AGE (In years last birthday) 52		10. IF UNDER 1 YEAR Months Days 52	
11. IF UNDER 24 HRS. Hours Min. 52		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mose Fennell		14. MOTHER'S MAIDEN NAME Minnie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary infarct DUE TO Chronic cor pulmonale DUE TO Scleroderma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7/10.0	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 24 years 24 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 3, 1962 to March 19, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 19, 1962 , and that death occurred at 11:00AM , from the causes and on the date stated above.			
22a. SIGNATURE Elliot Weser, M.D. M.D.		22b. DATE SIGNED 3/19/62	
22c. PHYSICIAN'S NAME (Type) Elliot Weser, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 3/20/62	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City, town or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 22 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03430 CERTIFICATE OF DEATH 03423

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON SAN. + HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NEW YORK b. COUNTY ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BATAVIA d. STREET ADDRESS 88 MAIN ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IVA Middle GRACE Last HESS		4. DATE OF DEATH Month 3 Day 26 Year 1962	
5. SEX FE	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Pa.
13. FATHER'S NAME William Hoover		14. MOTHER'S MAIDEN NAME Elizabeth Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHOLEMIC NEPHROSIS AND UREMIA 591X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CHOLECYSTOMY WITHIN PAST WEEK FOR CHOLELITHIASIS			INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-18-62 19 to 3-25-62 19 , that (I) (we) last saw the deceased alive on 3-25-62 19 , and that death occurred 12:15 AM , from the causes and on the date stated above.			
22a. SIGNATURE W. H. Ferguson MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W. H. Ferguson MD		22d. ADDRESS 915 19th St NW, DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF March 28-1962	23c. NAME OF CEMETERY OR CREMATORY Watts Cemetery	23d. LOCATION (City, town or county) Kerrmore (State) Penn.
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters		25a. REC'D BY REGISTRAR DATE MAR 28 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

0383

WEST VIRGINIA

0383

(M)

(1)

3-18-25 3-25-25

W. H. Harrison

W. H. Harrison

W. H. Harrison

W. H. Harrison

W. H. Harrison

W. H. Harrison

W. H. Harrison

CERTIFICATE OF DEATH

Reg. Dist. No. 03424

03431

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton 37</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2502 Arcola Ave.</u>		d. STREET ADDRESS <u>2502 Arcola Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLIE</u> Middle <u>LOUISE</u> Last <u>HIGDON</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1906</u>
9. AGE (In years lost birthday) yrs. <u>55</u>		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenn.</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Louise Rice</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Dorothy Anne Laney, 703 Fletcher Place</u>		Address <u>Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PSEUDO MUCINOUS CARCINOMA OF OVARY</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 11, 1962</u> to <u>MAR 30, 1962</u> , that I last saw the deceased alive on <u>MAR 30, 1962</u> , and that death occurred at <u>7:00 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Duohy</u> M.D.		ADDRESS (Street, city or town, state) <u>7720 WISCONSIN AVE BETHESDA, MD.</u>	
PHYSICIAN'S NAME (Type) <u>7720 WISCONSIN AVE BETHESDA, MD.</u>		DATE SIGNED <u>3/30/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-4-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HIGHLAND PARK</u>	22d. LOCATION (City, town, or county) (State) <u>MAYFIELD, KY</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chary Chase Funeral Home</u>		24a. REC'D BY REGISTRAR <u>5101 White Pine</u> DATE <u>APR 4 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03432

CERTIFICATE OF DEATH

03425

Item 18 Film G309 3/22/62 ams

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, 1638-2	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in 1b 52 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 4807 - 70th Place, Woodlawn	
3. NAME OF DECEASED (Type or print) First William (No middle name) Middle Hite Last		4. DATE OF DEATH Month March Day 16, Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 September 1923
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Central Office Repairman Telephone Company		12. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
13. FATHER'S NAME Russell Hite		14. MOTHER'S MAIDEN NAME Ruth Kuhnert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 579-20-8884	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Bronchopneumonia and septicemia (c) Acute leukemia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from January 23, 1962 to March 16, 1962, that (I) (we) last saw the deceased alive on March 16, 1962, and that death occurred at 6:10 AM from the causes and on the date stated above.			
22a. SIGNATURE Robert H. Levin, M.D.		22b. DATE SIGNED Mar 16, 1962	
22c. PHYSICIAN'S NAME (Type) Robert H. Levin		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-19-1962	
23c. NAME OF CEMETERY OR CREMATORY Arlington Natl		23d. LOCATION (City, town or county) (State) 2x Myer, Va	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A Mattingly		25a. REC'D BY REGISTRAR MAR 20 '62	
25b. REGISTRAR'S SIGNATURE C. L. Hume			

2540

92450

• 1951

705-710

et al.

i. 6. 1. 1.

SECRET

• iv •

2

trust in I

03433

CERTIFICATE OF DEATH

Reg. Dist. No. 03426

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLLEGE PARK	
c. LENGTH OF STAY IN 1b 2 1/2 yrs		d. STREET ADDRESS BERWYN ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION JOHNSONS NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JULIA First Middle Last HOLLAN		4. DATE OF DEATH MARCH 15 19 62 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 16, 1876
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) HUNGARY		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Rest Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive heart failure DUE TO (b) Generalized arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1960 , to March 15, 1962 that I last saw the deceased alive on March 15, 1962 , and that death occurred at 8:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. F. Thibadeau		M.D. 1011 COLESVILLE RD DATE SIGNED 3/15/62	
PHYSICIAN'S NAME (Type) A. F. THIBADEAU, M.D.		SILVER SPRING MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/62	
22c. NAME OF CEMETERY OR CREMATORY FT Lincoln		22d. LOCATION (City, town, or county) (State) Calmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. March's Sons Hyattsville, Md		ADDRESS	
24a. REC'D BY REGISTRAR MAR 19 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed on 24 hours after death. Page 1 of 4. The law requires that the death certificate be executed on 24 hours after death. Page 1 of 4. The law requires that the death certificate be executed on 24 hours after death. Page 1 of 4.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03434

03427

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Silver Spring c. LENGTH OF STAY IN 1b LeDeau d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington - District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1900 F. Street, N. W., apt. d. STREET ADDRESS 1900 F. Street, N. W., apt. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SELDEN GRANT First Middle Last HOPKINS		4. DATE OF DEATH Month Day Year March 30 1962	
5. SEX M	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1862
9. AGE (In years last birthday) 99 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 99	
11. BIRTHPLACE (County & State, or foreign country) Castle Rock, Wis.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Hopkins		14. MOTHER'S MAIDEN NAME not known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Philip S. Hopkins, 3900 16th St., N. W.		Address Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transition 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aging DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Heart Disease (Mild Failure Compensated)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from Feb 19, 1962 to Mar 30, 1962 , that (I) (we) last saw the deceased alive on Mar 30, 1962 , and that death occurred at 11:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Robert T. Thibadeau M.D.		22b. DATE SIGNED Mar 30-62	
22c. PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU		22d. ADDRESS 10609 CONCORD ST. KENSINGTON, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF April 2, 1962	
23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City, town or county) (State) Fairfax County, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Gray		25a. REC'D BY REGISTRAR APR 3 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Hume		25c. ADDRESS 2847 Wilson Blvd., Arlington, Va.	

03487

(M)

(I)

FELDEN GRANT

July 3, 1965

replied - Board of Appeals - Civil Service

Jacob Hopkins

Replied to Hopkins, June 15, 1965, N.H.
Washington, D.C.

Mar 30-65
KENSINGTON

North, 1965
New South Wales, Inc.

2818 Wilson Blvd., Arlington, Va.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7(1)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03435
CERTIFICATE OF DEATH
03428

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Derwood</u> d. STREET ADDRESS <u>Redland Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul</u> First <u>Edmund</u> Middle <u>Hottinger</u> Last 4. DATE OF DEATH <u>March</u> <u>7</u> <u>1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-4-22</u> 9. AGE (In years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Field Man Insp.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Elec.-Pub. Utility</u> 11. BIRTHPLACE (County & State, or foreign country) <u>W. Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wilbur Hottinger</u> 14. MOTHER'S MAIDEN NAME <u>Florence Brady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>218-18-5368</u> 17. INFORMANT <u>Washington Sanitarium & Hospital Records</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Brain stem compression</u> 2377X DUE TO <u>Suspected brain tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>3 weeks</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Left hemiparesis, cause unknown 6 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>2-23-19</u> Hour e.m. <u>2:30</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 21. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> <u>1962</u> to <u>3/7</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>3/7</u> <u>1962</u> and that death occurred at <u>9:00</u> <u>A.M.</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>John T. Lord and</u> 22c. PHYSICIAN'S NAME (Type) <u>John T. Lord and</u> 22b. DATE SIGNED <u>3/7/62</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1015 Spring St.</u> <u>Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-10-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Flower Hill</u> 23d. LOCATION (City, town or county) (State) <u>Redland, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Maryland</u> 25a. REC'D BY REGISTRAR <u>WAR 12 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

(M)

03132

03132

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Kilpatrick" and "Hollister" are faintly visible.]

[Faint text at the bottom of the page, possibly a footer or additional notes.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

99

1

0

2

MEDICAL CERTIFICATION

Maryland State Department of Health Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH																
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Silver Spring</u> d. STREET ADDRESS <u>1804 Burlington Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <u>James Clifton Housley</u>			4. DATE OF DEATH <u>3 13 1962</u>			5. SEX <u>male</u>			6. COLOR OR RACE <u>white</u>							
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>March 10, 1910</u>			9. AGE (In years last birthday) <u>52</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.														
Months	Days	Hours	Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Appliance Store</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>								
13. FATHER'S NAME <u>Albert Junior Housley</u>						14. MOTHER'S MAIDEN NAME <u>Estella Hill</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>300-07-3457</u>		17. INFORMANT <u>John Henry Housley</u>				Address <u>Takoma Park, Md. 6609 Poplar St Park</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <u>Frank J. Broschant</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED							
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Mar 13-1962</u>							
Address (Street, city, town, or county)						22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										
22b. DATE THEREOF <u>3-16-62</u>			22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			22d. LOCATION (City, town, or country) <u>Prince George's Co, Maryland</u>			(State)							
23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u>						Address <u>434 Georgia Ave</u>			24a. REC'D BY REGISTRAR <u>WAR 15 '62</u>							
Warner E. Pumphrey, Inc., Silver Spring, Maryland						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krome</u>			DATE							

(M)

James Clark

D.O.B.

3.12.1911

Mrs. Clark

James Clark

3.12.1911

Mrs. Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

James Clark

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03430

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda 57</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6105 Wynnwood Rd</u>				d. STREET ADDRESS <u>6105 Wynnwood Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Daisy Frances Huddleson</u>				4. DATE OF DEATH <u>Mar 25 1962</u>			
5. SEX <u>Female</u>		6. COLOR OF RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 13 1897</u>	
9. AGE (In years last birthday) <u>64 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - U.S. Treasury</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charlie F. Cornell</u>				14. MOTHER'S MAIDEN NAME <u>Annie Belle Rutter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-60-1390</u>		17. INFORMANT <u>Harvey Huddleson (husband)</u> Address <u>Stu 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. } DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>62</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschelt</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschelt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/29/62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>				22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>William L. Krause</u>			
DATE <u>MAR 27 '62</u>							

00130

00130

M

S

00130

00130

00130

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03438

03431

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY IN lb <i>3 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont. Co.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>31 Silver Spring</i> d. STREET ADDRESS <i>130-Woodridge Ave.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Willard Phillips Hummell</i> First Middle Last		4. DATE OF DEATH <i>March 14 1962</i> Month Day Year	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/26/03</i>
9. AGE (In years last birthday) <i>59</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerical</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Lynn Mass.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Wm. Hummell</i>	
14. MOTHER'S MAIDEN NAME <i>Abbie Phillips</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> 16. SOCIAL SECURITY NO. <i>030-03-7777</i>	
17. INFORMANT <i>Hazel T. Hummell</i> Address <i>130 Woodridge Ave. Silver Spring, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia + congestive heart failure</i> DUE TO (b) <i>Acute cor pulmonale</i> DUE TO (c) <i>Pulmonary emphysema</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> <i>3 weeks + 20 years</i>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Carcinoma of bladder + prostate.</i>	
21. DATE OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		22. TIME OF INJURY While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)	
25. I certify that (I) (this hospital) attended the deceased from <i>March 11, 1962</i> to <i>March 14, 1962</i> , that (I) (we) last saw the deceased alive on <i>March 14, 1962</i> , and that death occurred at <i>6:00 P.M.</i> from the causes and on the date stated above.		26. SIGNATURE <i>Blaine H. ETC</i> M.D.	
27. PHYSICIAN'S NAME (Type) <i>BLAINE H. ETC</i>		28. ADDRESS <i>8641 Colasville Rd Silver Spring, Md.</i>	
29. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		30. DATE THEREOF <i>2-17-62</i>	
31. NAME OF CEMETERY OR CREMATORY <i>Forrest Hill Cemetery</i>		32. LOCATION (City, town or county) (State) <i>Fitchburg, Worcester Co., Mass.</i>	
33. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Galt</i> <i>Warner E. Pumphrey, Inc., Silver Spring, Maryland</i>		34. REC'D BY REGISTRAR <i>March 19 1962</i>	
35. REGISTRAR'S SIGNATURE <i>Anthony S. Kraus</i>			

10000

00000

(M)

(1)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

[Faint handwritten text at the bottom of the page, including what appears to be a signature and some notes.]

TO HOSE: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03432

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Silver Spring</u> d. STREET ADDRESS <u>1612 Neeley Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Maxwell</u> Middle <u>Hunt</u> Last		4. DATE OF DEATH <u>March</u> Month <u>30</u> Day <u>1962</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-13</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>auto mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>auto - garage</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Newfoundland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Hunt</u>	
14. MOTHER'S MAIDEN NAME <u>Elsie (does not remember)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give year or dates of service) <u>WW 2 - army</u>	
16. SOCIAL SECURITY NO. <u>chart - hospital records - O. Lindsay.</u>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Congestive Heart Failure</u> DUE TO (b) <u>Bronchial Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Bronchial Asthma Chronic Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One Hour</u> <u>Several Days</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>March 28, 1962</u> to <u>March 30, 1962</u> , that (I) (we) last saw the deceased alive on <u>March 30, 1962</u> and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Stuart D. Nelson</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3-30-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>STUART D. NELSON</u>		22d. ADDRESS <u>NASH. SAN + HOSP.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>April 3, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hall</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, VA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. T. Atwood</u> ADDRESS <u>3603 14th St NW</u>		25a. REC'D BY REGISTRAR <u>10</u> DATE <u>APR 2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

03185

M

STREET & HAZARD

CHAS. W. BENTLEY

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03440

03433

1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Spencerville, Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>Thompson Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Ida Mae Jackson</i>		4. DATE OF DEATH Month Day Year <i>March 26 1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 30/21</i>
9. AGE (In years last birthday) <i>41</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Clifton George Thomas</i>	
14. MOTHER'S MAIDEN NAME <i>Mary ?</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>217-32-1344</i>		17. INFORMANT Name Address <i>Milton Jackson Jr. Above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Chronic Pulmonary Emphysema.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> <i>5 years</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>3/26/62</i>, 19<i>62</i>, to <i>3/26</i>, 19<i>62</i>, that (I) (we) last saw the deceased alive on <i>3/26</i>, 19<i>62</i>, and that death occurred at <i>7 PM</i>, from the causes and on the date stated above.			
22a. SIGNATURE <i>John E. Everett</i> M.D.		22b. DATE SIGNED <i>3/26/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN E. EVERETT</i>		22d. ADDRESS <i>9400 Conn Ave Kensington</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>3/30/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Round Oak.</i>	23d. LOCATION (City, town or county) (State) <i>Spencerville, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		25a. REC'D BY REGISTRAR <i>Rockville, Md.</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

2240



05/2

542

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A1SME
SM 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Mont.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda										c. LENGTH OF STAY IN 1b DOA									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Silver Spring									
d. STREET ADDRESS 15740 Goodhope Rd.										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Louis Middle Nathanial Last Jackson										4. DATE OF DEATH Month March Day 2 Year 1962									
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1/23/1900		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer										10b. KIND OF BUSINESS OR INDUSTRY Maryland									
11. BIRTHPLACE (State or foreign country) Maryland										12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Louis B. Jackson										14. MOTHER'S MAIDEN NAME Laura Johnson									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)										16. SOCIAL SECURITY NO. Hester H. Hackley,									
17. INFORMANT item 2										Address item 2									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to cold 932.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Acute alcoholism (c) Found dead in an unheated tool shed at home.										INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. 19 p.m.										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart										M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) Frank J. Broschart										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-2-62									
Address (Street, city, town, or county)																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF 3/4/62									
22c. NAME OF CEMETERY OR CREMATORY Sandy Spring,										22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.									
23. FUNERAL DIRECTOR Robert L. Swoden										ADDRESS Rockville, Md.									
24a. REC'D BY REGISTRAR 7 '62										24b. REGISTRAR'S SIGNATURE Arthur L. Hester									

10000

10000



03442

CERTIFICATE OF DEATH

03435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>3719 Kayson St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Chester</i> Middle <i>Clayton</i> Last <i>James</i>		4. DATE OF DEATH Month <i>March</i> Day <i>23</i> Year <i>1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 23, 1922</i>
9. AGE (In years last birthday) <i>39</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles E. James</i>		14. MOTHER'S MAIDEN NAME <i>Essa E. Thompson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>577-22-8374</i>	
17. INFORMANT <i>Mrs. Charles E. James - Same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 29, 1961</i> , to <i>March 23, 1962</i> , that I last saw the deceased alive on <i>March 23, 1962</i> , and that death occurred at <i>6:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip E. Jones</i>		ADDRESS (Street, city or town, state) <i>918 Silver Spring Blvd. Silver Spring, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>		DATE SIGNED <i>3/23/62</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Mar 26-62</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Seatons Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sammond Bros. Funeral Home</i>		ADDRESS <i>1661 - Good Hope Rd Wash DC</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haines</i>	
DATE <i>MAR 27 '62</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
03443
03436
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4949 Battery Lane		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 46 Bethesda d. STREET ADDRESS 1 4949 Battery Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE WALDEMAR JENSEN		4. DATE OF DEATH Month Day Year MARCH 20 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 6, 1886
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping - Steam Ship - Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Copenhagen, Denmark		12. CITIZEN OF WHAT COUNTRY Naturalized.	
13. FATHER'S NAME Waldemar Jensen		14. MOTHER'S MAIDEN NAME Hansine Jensen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife Address Johanna Jensen Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE WITH INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) GENERALIZED ARTERIOSCLEROSIS & ARTERIOCLEROSIS 29 YRS. (c) HEART DISEASE QUADRIPLEGIC LAST 4 MONTHS, RESULTING		INTERVAL BETWEEN ONSET AND DEATH 2 HRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CUA WITH CORD INJURY - FOUR MONTHS AGO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work el work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY 1950 to MAR 20, 1962 that (I) (we) last saw the deceased alive on MAR 20, 1962 , and that death occurred at 12:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE William B. Walsh M.D. M.D.		22b. DATE SIGNED MAR 20 1962	
22c. PHYSICIAN'S NAME (Type) WILLIAM B. WALSH M.D.		22d. ADDRESS 1835 EYE ST. N.W. - WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 3/23/62	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory	23d. LOCATION (City, town or county) (State) Prince George Co., Md.
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE MAR 23 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

(M)

(A)

ROBERT A. FERNER

Bethesda, Md.

Operation 310762 22. Lincoln Cemetery Prince George's Co., Md.

William B. Smith 1937 Dec 17.0.0 - 1944

Robert B. Smith

COA with 1000 copies - 1000 copies

Investigate (copy) (copy) (copy) (copy)

General (copy) (copy) (copy) (copy)

Investigate (copy) (copy) (copy) (copy)

Johanna Jensen 2000 20 1000 20

Bathurst Jensen

Shipping - Steam ship - 1000

Goodman, 1000 1000 1000

Male White

Dot. 5, 1800 75

1000 Battery Lane

1000 Battery Lane

Bethesda

Bethesda

1000

1000

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03444
CERTIFICATE OF DEATH
03437

1. PLACE OF DEATH e. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marilea Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Silver Spring d. STREET ADDRESS 10,400 Hayes Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas H. Johnson		4. DATE OF DEATH Month March Day 6 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1875
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 8 Days 15	
IF UNDER 24 HRS. Hours 15 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Egg salesman		10b. KIND OF BUSINESS OR INDUSTRY Own business	
11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 579-28-1657	
17. INFORMANT Mrs. Elmer W. Michels		Address 10,400 Hayes Ave, S.S., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from December 1961 to March 6, 1962 , that (I) (we) last saw the deceased alive on March 5, 1962 , and that death occurred at 11:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Bennet A. Porter, Jr. M.D.		22b. DATE SIGNED March 7, 1962	
22c. PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr., M.D.		22d. ADDRESS 9301 Coleville Rd, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-9-62	23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	23d. LOCATION (City, town or county) (State) Washington, D.C.
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey		25a. REC'D BY REGISTRAR Warner E. Pumphrey, Inc. Silver Spring, Md.	
25b. REGISTRAR'S SIGNATURE Anthony S. K...		DATE MAR 9 '62	



Memorandum

Subject: [Illegible]

Reference: [Illegible]

Date: [Illegible]

By: [Illegible]

For: [Illegible]

File: [Illegible]

Re: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

W. H. [Illegible]

100 [Illegible]

W. H. [Illegible]

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03445

03438

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>P.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San & Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Essex</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tappahannock</u> d. STREET ADDRESS <u>Box 56</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EVA LORRANE Johnston</u> First Middle Last		4. DATE OF DEATH <u>3-6-1962</u> Month Day Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-79</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Own & home</u>	9. AGE (In years last birthday) <u>82</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own & home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>West VA</u>
13. FATHER'S NAME <u>FRANKLIN Beck</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MR. O M. JONES</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Severe Arteriosclerosis</u> (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>11 Feb</u>		20g. (County) <u>Essex</u>	
20h. (State) <u>1962</u>		20i. (City or town) <u>11 Feb</u>	
20j. (County) <u>Essex</u>		20k. (State) <u>1962</u>	
21. I certify that (I) (the hospital) attended the deceased from <u>11 Feb</u> to <u>6 Mar</u> 1962 that (I) (we) last saw the deceased alive on <u>5 Mar</u> 1962 and that death occurred at <u>7:12 AM</u> from the causes and on the date stated above.		22a. SIGNATURE <u>H. B. Queen</u> M.D.	
22b. DATE SIGNED <u>7 Mar 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>H. B. Queen</u>	
22d. ADDRESS <u>7112 Willow Acad</u> <u>Takoma Park Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE THEREOF <u>3-9-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	
23d. LOCATION (City, town or county) <u>Fredericksburg Spottsylvania Co</u>		23e. (State) <u>Tappahannock Essex Co Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Fisher</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Anthony J. Harris</u>		25c. ADDRESS <u>434 Georgia Ave</u> <u>Silver Spring, Maryland</u>	

03138

(M)

(1)

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

[Faint, mostly illegible printed text at the bottom of the page, likely a footer or address block.]

TO HOSTEL: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

Coroner notified and approved

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03446

03439

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 23 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MD b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 BETHESDA (WESTHAVEN) d. STREET ADDRESS 15103 BROOKVIEW DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MOLLIE Middle C. Last JUMP		4. DAY OF DEATH Month MAR Day 12 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 JUNE 1864
9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLEICAL		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV	11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL ADAMS CLICKNER	
14. MOTHER'S MAIDEN NAME JANE REED		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR K. FOOTE Address ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 522X DUE TO Conditions, if any, which gave rise to immediate cause (b) GENERAL DETERIORATION (e), stating the underlying cause (c) HYPOSTATIC PNEUMONIA FRACTURE LT HIP		INTERVAL BETWEEN ONSET AND DEATH 12 MAR 62 14 FEB 62	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) FRACTURE LT HIP			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PT FELL AT HOME	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12 FEB 14 62 p.m. NONE		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) WEST HAVEN MONT. MD	
21. I certify that (I) (this hospital) attended the deceased from 15 FEB. , 19 62 to 12 MAR. , 19 62 , that (I) (two) last saw the deceased alive on 9 MAR. , 19 62 , and that death occurred at 3 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Marvin M Gibson M.D.		22b. DATE SIGNED 12 MAR 62	
22c. PHYSICIAN'S NAME (Type) MARVIN M GIBSON		22d. ADDRESS 1835 FYE ST NW WASH DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3/14/62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		25a. REC'D BY REGISTRAR 2901 14th St. N.W. MAR 14 '62 DATE Washington 9, D.C.	
25b. REGISTRAR'S SIGNATURE Carroll S. Thomas			

00000

DEPARTMENT OF DEFENSE

00000

(M)

RECEIVED AND DELIVERED TO THE

UNITED STATES OF AMERICA

THE SECRETARY OF DEFENSE

TO HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03447					03440					
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Alexandria					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					d. STREET ADDRESS 941 N. VanDoren					
3. NAME OF DECEASED (Type or print) First Middle Last Lucille Marie Juskie					4. DATE OF DEATH Month Day Year March 20, 1962					
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 24, 1926		9. AGE (In years last birthday) 35 39 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lake Charles, La.		12. CITIZEN OF WHAT COUNTRY USA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13. FATHER'S NAME H. L. PEARCE					14. MOTHER'S MAIDEN NAME Laura Barrett					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 437 24 5927		17. INFORMANT Address HUSBAND: Ben Juskie, Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Brain Metastasis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 6, 1962 , to March 20, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 20, 1962 , and that death occurred 1:00 PM from the causes and on the date stated above.										
22a. SIGNATURE William C. Monell M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 20, 1962			
22c. PHYSICIAN'S NAME (Type) WILLIAM C. MONELL LT MC USA					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-23-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE Everly-Wheatley Funeral Home, Alexandria, Va.					ADDRESS Everly-Wheatley Funeral Home, Alexandria, Va.		25a. REC'D BY REGISTRAR DATE MAR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Klaus	

15

2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 26

4

சென்னை

2005 1 12

WILLIAM C. JOHNSON, JR.

11/24/2017, 10:28:52

120158 1985 120158

1911-1912

$$0.1 \times 10^{-3} \text{ mol/L} \times 100 \text{ mL} = 0.01 \text{ mol/L} \times 10 \text{ mL}$$

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03448

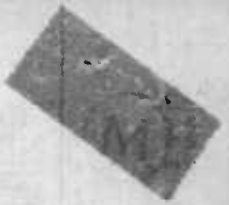
CERTIFICATE OF DEATH

03441

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington, 42 d. STREET ADDRESS 10604 Wheatley Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Herbert (No middle name) Kahler				4. DATE OF DEATH Month March Day 29, Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 December 1896	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 20		11. IF UNDER 24 HRS. Hours 6 Mins. 20		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bio. Physicist & P.H.D. Federal Government				10b. KIND OF BUSINESS OR INDUSTRY Oregon			
13. FATHER'S NAME Orange Kahler				14. MOTHER'S MAIDEN NAME Lena Dunlap			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland				18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Lymphatic Leukemia DUE TO 20404 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia DUE TO (c) Possible viral hepatitis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 26, 1962 to March 29, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 29, 1962 , and that death occurred at 10:20 AM , from the causes and on the date stated above.							
22a. SIGNATURE Martin J. Cline M.D.				22b. DATE SIGNED 3/29/62			
22c. PHYSICIAN'S NAME (Type) Martin J. Cline, MD.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/62		23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE APR 2 '62			
25b. REGISTRAR'S SIGNATURE Arthur S. Hume							

02111

02111



The Office of the Secretary of the
Department of the Interior
Washington, D. C.
February 1, 1902
To the Honorable Secretary of the
Department of the Interior
Washington, D. C.
Dear Sir:
I have the honor to acknowledge
the receipt of your letter of
January 28, 1902, in relation
to the matter of the
application of the
Department of the Interior
for the purpose of
obtaining a license
to operate a
certain kind of
business in
the Territory of
New Mexico.

Very respectfully,
Robert A. Thompson, Secretary,
Department of the Interior,
Washington, D. C.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages 1 and 2 are retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03449

03442

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> c. LENGTH OF STAY in lb <i>16 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Mont. Co.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>58 Cabin John</i> d. STREET ADDRESS <i>6516-76th Pl.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>George E. Kane</i>				4. DATE OF DEATH Month Day Year <i>March 9 1962</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6/16/94</i>	
9. AGE (In years and birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>U</i>		11. BIRTHPLACE (County & State, or foreign country) <i>D.C.</i>	
13. FATHER'S NAME <i>George Kane</i>				14. MOTHER'S MAIDEN NAME <i>Annie Behrens</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>578-20-5261A</i>		17. INFORMANT <i>Robert Kearney</i> Address <i>#414-35th St. N.W. Wash., D.C.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute generalized peritonitis</i> 5410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Meas, duodenum</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/24</i> , 19 <i>62</i> , to <i>3/9</i> , 19 <i>62</i> ; that (I) (we) last saw the deceased alive on <i>3/9</i> , 19 <i>62</i> , and that death occurred at <i>9 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>W. F. Joyce</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3/10/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. F. JOYCE</i>				22d. ADDRESS <i>8106 MAPLE RIDGE RD. BETHESDA, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-12-62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>mt Olivet Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis J. Collins</i>				ADDRESS <i>3821 14th St. Wash., D.C.</i>		25a. RECD BY REGISTRAR <i>12</i> 25b. REGISTRAR'S SIGNATURE <i>Arthur L. Haines</i>	

00012

(M)

7

George Kane

Annie Johnson

W. F. Jones

March 3-12-12

W. F. Jones

W. F. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03450

CERTIFICATE OF DEATH

Reg. Dist. No. 03443

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C. 47X'3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL				d. STREET ADDRESS 1416 Holly St NW, WASH.			
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE S. KAUFFMAN				4. DATE OF DEATH Month Day Year 3 16 1962			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-89		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Summerville				14. MOTHER'S MAIDEN NAME Margaret H. McCaskey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Harvey E. Kauffman Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 wks. 7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-10 , 19 62 , to 3-16 , 19 62 , that I last saw the deceased alive on 3-16 , 19 62 , and that death occurred at 8:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10511 Summitt Avenue 3-16-62							
ACTUAL SIGNATURE Richard H. Pollen		M.D. 10511 Summitt Avenue					
PHYSICIAN'S NAME (Type) Richard Henry Pollen, M.D. Kensington, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-20-62		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Warner Warner E. Pumphrey, Inc. Silver Spring, Maryland				24a. REC'D BY REGISTRAR MAR 20 '62		24b. REGISTRAR'S SIGNATURE Carlton L. K...	

CERTIFICATE OF DEATH

1918

M

DECEASED

DATE OF DEATH

12 21

PLACE OF DEATH

HOME

AGE

65

SEX

MALE

RACE

WHITE

EDUCATION

HIGH SCHOOL

PROFESSION

TEACHER

RELIGION

METHODIST

CAUSE OF DEATH

HEART DISEASE

SYMPTOMS

CHEST PAIN

SHORTNESS OF BREATH

SWELLING OF FEET

WEIGHT LOSS

LOSS OF APPETITE

GENERAL WEAKNESS

CONSTIPATION

HEADACHE

INDIGESTION

NERVOUSNESS

SLIGHT FEVER

COUGH

SPITTING OF BLOOD

HAEMOPTYSIS

HYDROTHORAX

EMPHYSEMA

ASTHMA

BRONCHITIS

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. It must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03444

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47X-3</u> d. STREET ADDRESS <u>3735 Jocelyn ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
3. NAME OF DECEASED (Type or print) <u>Thomas Spriggs Kelley</u>				4. DATE OF DEATH <u>March 25 1962</u>																					
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-22-81</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>													
13. FATHER'S NAME <u>James Kelley Jr</u>				14. MOTHER'S MAIDEN NAME <u>Felicia Elizabeth Spriggs</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>- - - - -</u>						17. INFORMANT <u>ms. Enid Anthony - sister</u> Address <u>9 days</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cancer Prostate & Metastases</u> DUE TO (c) <u>4 years</u>												INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>																					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19....., to <u>3-25</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3-25</u> , 19 <u>62</u> , and that death occurred at <u>.....</u> M, from the causes and on the date stated above.																									
22a. SIGNATURE <u>Lutes Blumenthal</u> M.D.												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <u>5315 CONN. AVE. WASH. D.C.</u>												22d. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>3-26-1962</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Rehoboth Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Rehoboth, Va.</u>													
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Lawrence Smith</u> ADDRESS <u>1756 Pa. Ave SW Washington, D.C.</u>												25a. REC'D BY REGISTRAR <u>MAR 27 '62</u> DATE				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>									

100111

CERTIFICATE OF DEATH

1951

(M)

John

Thomas

White

Partner

Recorded

11-15-1952

Removal

03452

CERTIFICATE OF DEATH

03445

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15</u> d. STREET ADDRESS <u>621 Hollywood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harold</u> <u>Leon</u> <u>Kelly</u>			4. DATE OF DEATH Month Day Year <u>March</u> <u>26</u> <u>1962</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/11/93</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fed. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>			
13. FATHER'S NAME <u>Charles W. Kelly</u>			14. MOTHER'S MAIDEN NAME <u>Julia Lee</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>217-34-1593</u>		17. INFORMANT Address <u>Wash. San. & Hosp. Carroll Ave., Takoma Park, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>157 X</u> IMMEDIATE CAUSE (a) <u>Carcinomatosis, generalized</u> {PRIMARY IN TAIL OF PANCREAS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>6 months +</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lobar pneumonia, with hydrothorax</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , to <u>Mar. 26, 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar. 26, 1962</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>John N. Andrews</u> M.D. 22b. DATE SIGNED <u>3-27-62</u> 22c. PHYSICIAN'S NAME (Type) <u>John N. Andrews</u> 22d. ADDRESS <u>9601 Colesville Rd Silver Spring Md</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-29-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Hyattsville Pr. George's Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Warner</u> ADDRESS <u>434 Georgia Ave</u> 25a. REC'D BY REGISTRAR <u>Mar 29 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>							

MEDICAL CERTIFICATION

2

1

BP

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2130

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

2017-2018

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 are retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03453
CERTIFICATE OF DEATH

03446

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in lb 3days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C. d. STREET ADDRESS 4509 Butterworth Place, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary F. Kelly		4. DATE OF DEATH Month Day Year 3 - 10 - 1962	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/13/83 9. AGE (In years) 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY - - - 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON DC. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ANDREW MILLS 14. MOTHER'S MAIDEN NAME ELIZABETH AHERN.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No No 16. SOCIAL SECURITY NO. - - - 17. INFORMANT MARGT KELLY Address 4509 Butterworth Pl. N.W. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarct, rt. lower lobe 465X DUE TO Conditions, if any, which gave rise to immediate cause (b) Thrombosis, pulmonary artery, rt. lower (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from 3/1/1962, 1962 , that (I) (we) last saw the deceased alive on 3/10/62, and that death occurred at 9P.M. from the causes and on the date stated above.			
22a. SIGNATURE Marvin Wadler 22c. PHYSICIAN'S NAME (Type) Dr. Marvin Wadler 22d. ADDRESS 8816 Maywd. Ave., Silver Spring			
22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3-14-1962 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 23d. LOCATION (City, town or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE Joe. Gawler Sons, Inc. 1756 PA. AVE. N.W. WASH., D.C. 25a. REC'D BY REGISTRAR DATE MAR 13 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

03416

03416



3-14-1963 Mr. Chief Cemetery
Washington, D. C.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03454

03447

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN b 20 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kensington Gardens Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Silver Spring, Maryland d. STREET ADDRESS 1515 E. Falkland Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edith W. Kidwell		4. DATE OF DEATH Month Day Year March 10 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1882
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Grenville Whitaker		14. MOTHER'S MAIDEN NAME Laura S. Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No None		16. SOCIAL SECURITY NO. 577-05-20978	
17. INFORMANT Robert W. Kidwell		Address 314 Northwest Dr. Silver Spring Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 420.0 DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to March 10, 1962 that (I) (we) last saw the deceased alive on March 10, 1962 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. Marion Barkhead M.D. 22b. PHYSICIAN'S NAME (Type) J. Marion Barkhead		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 9241 Col. Blvd Silver Spring, Md. 22b. DATE SIGNED 3/10/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-14-62	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zinke Warner E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR MAR 13 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

77390

12

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03455

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03448

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>montg</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg (rural)</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Clarksburg</u>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>Johnson Rd</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Ernest W. King</u>					4. DATE OF DEATH <u>mar. 1 1962</u>				
5. SEX <u>male</u>					6. COLOR OR RACE <u>white</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>10-28-82</u>				
9. AGE (In years last birthday) <u>79</u> yrs.					10. IF UNDER 1 YEAR Months Days				
11. IF UNDER 24 HRS. Hours Min.					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>				
11. BIRTHPLACE (State or foreign country) <u>md</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John B King</u>					14. MOTHER'S MARRIED NAME <u>Lilly Burns</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)					16. SOCIAL SECURITY NO. <u>Yes</u>				
17. INFORMANT <u>Lee King - Cedar Grove, md</u>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>hypertension</u> DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>yes</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
Address (Street, city, town, or county)									
DATE SIGNED <u>3-1-62</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
22b. DATE THEREOF <u>3/3/62</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Methodist</u>									
22d. LOCATION (City, town, or county) (State) <u>Browningsville, Md.</u>									
23. FUNERAL DIRECTOR: <u>Olin L. Molesworth</u>									
24a. REC'D BY REGISTRAR <u>DAMAR</u> 5 '62									
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>									

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03456
CERTIFICATE OF DEATH
03449

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takeka Park</u> c. LENGTH OF STAY IN IB <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash SAN & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Silver Spring</u> d. STREET ADDRESS <u>10400 Colesville Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elinor Matilda Kinsman</u>		First <u>Matilda</u> Middle <u>Kinsman</u> Last <u>Kinsman</u>		4. DATE OF DEATH <u>MARCH 16 1962</u>		Month <u>March</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-72</u>		9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Oliver Kinsman</u>				14. MOTHER'S MAIDEN NAME <u>Emma Richardson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hosp. Record-</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Cardiac decompensation</u> IMMEDIATE CAUSE (a) <u>422</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonitis; acute renal failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>many years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>January 1962</u> to <u>March 16, 1962</u> , that (I) (we) last saw the deceased alive on <u>March 15 1962</u> , and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.		22b. DATE SIGNED <u>March 16, 62</u>		22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>			
22d. ADDRESS <u>9301 Colesville Rd, Silver Spring, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>3-19-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville Montgomery Co, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24b. ADDRESS <u>434 Georgia Ave.</u>		24c. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc., Silver Spring, Maryland</u>		24d. DATE <u>MAR 19 '62</u>	
24e. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		24f. DATE <u> </u>					

01100

02100

M

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03457 CERTIFICATE OF DEATH 03450											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u>						c. LENGTH OF STAY IN 1b <u>13X-2</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>						d. STREET ADDRESS <u>Glenwood</u>					
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>CATHERINE</u> Last <u>KRAMER</u>						4. DATE OF DEATH Month <u>3-7</u> Day <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-1890</u>		9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Basil H. Grimes</u>						14. MOTHER'S MAIDEN NAME <u>Ida Tasker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mr. Fred Kramer (Husband) Glenwood, Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Strenuous hypertension, cardiac</u> DUE TO (c) <u>failure, cardiac arrest -</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1960 to 1962</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>7 March 1962</u> that (I) (we) last saw the deceased <u>7 March 1962</u> and that death occurred <u>8 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Howard E. Hall</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>7 March 62</u>		
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>						22d. ADDRESS <u>Spencerville, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-10-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Providence</u>		23d. LOCATION (City, town or county) (State) <u>Glenelg, Md</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>						ADDRESS <u>Ellicott City, Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 12 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

03150

CERTIFICATE OF DEATH

03150



Death occurred on the

DATE OF DEATH

2-7

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

1-1-10

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03458

CERTIFICATE OF DEATH

Item 23b, Film G308 3/12/62 iwk

03451

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, NNM				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Chevy Chase d. STREET ADDRESS 5053 Bradley Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Michael Middle Benjamin Last Krom				4. DATE OF DEATH Month March Day 1 Year 1962			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 November 1960	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 1		IF UNDER 24 HRS. Hours 1 Min. 10			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - -				10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (County & State, or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Byron Earnest Krom				14. MOTHER'S MAIDEN NAME Adlyn Lee			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. - - - -		17. INFORMANT Father: Byron Earnest Krom, same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 289.0 IMMEDIATE CAUSE (a) Hand-Schuller Christian Dis. DUE TO (b) 6 mo Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 6 mo DUE TO (c) 6 mo				INTERVAL BETWEEN ONSET AND DEATH 6 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from 17 February, 1962 , to 1 March, 1962 , that 1 (we) last saw the deceased alive on 1 March, 1962 , and that death occurred at 16:10 PM the causes and on the date stated above.							
22a. SIGNATURE H.A. Pearson M.D. 22c. PHYSICIAN'S NAME (Type) H.A. PEARSON, LCDR MC USN				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U.S. Naval Hospital		22b. DATE SIGNED 2 March 1962	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 5, 1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey Address Bethesda, Md.				25a. REC'D BY REGISTRAR 5 62		25b. REGISTRAR'S SIGNATURE Arthur S. Kras	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

VR A15 (4)
15M 7/61

08151

08151

Honorable

Honorable

Honorable

Chief Clerk

to

Director (101)

2003 Bureau Building

U.S. Naval Hospital, 1700

1

from

from

Director

Director

1

19 November 1960

1

1

U

North Carolina

Religion

Religion

Director: Byron B. Smith, Jr., and

1

19 November 1960

1:10 PM

1 March

U.S. Naval Hospital

U.S. Naval Hospital

[Handwritten signature]

03452

M

90

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

02425

CO-ORDINATE OF DEATH

02425

(M)

Montgomery

GERMANTOWN

Maryland Rest Home

Zone A

Female White

Huswife

2 Beach

No

None

former Kullman

20

Marj M. P. secy

Age 31/11 30

Wash DC

124

March 6 12

632-2125 or W

Washington DC

X

3/12/23 Congressmen Can Wash DC

Montgomery - 441-1100

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03460

03453

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN lb <u>5 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington SAN & Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1020 UNIVERSITY Bld.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Lyman Lamb</u>		4. DATE OF DEATH Last First Middle <u>March 4 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-78</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government ?</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Fed Gov't</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lyman H. Lamb</u>		14. MOTHER'S MAIDEN NAME <u>Martha Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Patients Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>42000</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerotic heart disease</u> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>curvature of spine</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-29-61</u> 19<u>61</u> to <u>3-4-62</u> 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>12-14</u> 19<u>61</u>, and that death occurred at <u>9:50</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur J. Willets</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Arthur J. Willets</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-7-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home Wash. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur J. Willets</u>			

12410

12410

(M)

(1)

pink

white

Government

Hyman H. Kamm

he

on the right

Patience Chart

D.C.

12-22-72

1952 University of

University of

Arthur J. White

12-14-72

12-14-72

12-14-72

University of

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Pages 1 and 2 shall be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03461

03454

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Hall Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Silver Spring d. STREET ADDRESS 12,502 Denley Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lilian First Mary Middle L A M B Last B		4. DATE OF DEATH 26 March 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1869
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect and clerk Ret.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Department	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Lamb		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Louise Darling		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE FAILURE DUE TO ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Semily; thrombophlebitis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 30, 1962 to 26 Mar, 1962 , that (I) (we) last saw the deceased alive on 22 Mar 1962 and that death occurred at 12502 Denley Rd , from the causes and on the date stated above.			
22a. SIGNATURE Horace W. Bernton M.D.		22b. DATE SIGNED 3/26/62	
22c. PHYSICIAN'S NAME (Type) Horace W. Bernton		22d. ADDRESS 4743 Beadly Blvd, Ch Ch 15, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-28-62	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince George's County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		25a. REC'D BY REGISTRAR Warner E. Pumphrey, Inc. Silver Spring, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAR 30 '62	

03451

03451

Postmaster

Postmaster

Postmaster

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

Post Office

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN b. 12 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11912 Rockinghorse Road		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Rockville d. STREET ADDRESS 11912 Rockinghorse Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY L. LAWSON First Middle Last 4. DATE OF DEATH MARCH 25 1962 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 10/8/1900 9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia 11. BIRTHPLACE (County & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard B. Pace		14. MOTHER'S MAIDEN NAME Mildred E. Bowen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. same 17. INFORMANT Roy J. Lawson-Husband Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (b) 151X (a), stating the underlying cause last. } DUE TO (c) Rheumatic heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/23/62 to 3/25/62 that (I) (we) last saw the deceased alive on 3/23/62 , and that death occurred at 10:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Donald Nelson M.D.		22b. DATE SIGNED 3/25/62	
22c. PHYSICIAN'S NAME (Type) Donald Nelson		22d. ADDRESS 10620 Georgia Ave., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/62	
23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City, town or county) (State) Suitland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		25a. REC'D BY REGISTRAR MAR 28 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

6282

CERTIFICATE OF DEATH

Reg. Dist. No.

03456

03463

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>				d. STREET ADDRESS <i>Luckett Ave, P.O. Box 501</i>			
3. NAME OF DECEASED (Type or print) First <i>Lucy</i> Middle <i>Anne</i> Last <i>Lewis</i>				4. DATE OF DEATH Month <i>March</i> Day <i>28</i> Year <i>1962</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-13-1879</i>		9. AGE (In years last birthday) <i>83</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Culpepper -</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin Franklin Myers</i>				14. MOTHER'S M maiden name <i>Evelyn Brown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Evelyn K. Gore</i> Address <i>11601 Naam Rd, Silver Spring - Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO <i>Generalized Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>Bronchopneumonia</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchopneumonia</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-4-</i> <i>1962</i> , to <i>3-28-</i> <i>1962</i> , that I last saw the deceased alive on <i>2-25-</i> <i>1962</i> , and that death occurred at <i>10 30</i> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Joseph E. Smith, Jr.</i> M.D. <i>Burtonsville, Md.</i>				ADDRESS (Street, city or town, state) <i>Burtonsville, Md.</i> DATE SIGNED <i>3/28/62</i>			
PHYSICIAN'S NAME (Type) <i>Joseph E. Smith, Jr.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 31, 1962</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Church Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Lignum Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler</i> ADDRESS <i>East Montg. Ave Rockville, Maryland</i>				24a. REC'D BY REGISTRAR DATE <i>APR 2 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral home. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MADE IN U.S.A.
HALL COUNTY, GA.
JAN 10 1910

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery	
16. Signature of church		17. Signature of school		18. Signature of other	
19. Signature of other		20. Signature of other		21. Signature of other	
22. Signature of other		23. Signature of other		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other	
28. Signature of other		29. Signature of other		30. Signature of other	
31. Signature of other		32. Signature of other		33. Signature of other	
34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other	
40. Signature of other		41. Signature of other		42. Signature of other	
43. Signature of other		44. Signature of other		45. Signature of other	
46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other	
52. Signature of other		53. Signature of other		54. Signature of other	
55. Signature of other		56. Signature of other		57. Signature of other	
58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other	
64. Signature of other		65. Signature of other		66. Signature of other	
67. Signature of other		68. Signature of other		69. Signature of other	
70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other	
76. Signature of other		77. Signature of other		78. Signature of other	
79. Signature of other		80. Signature of other		81. Signature of other	
82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other	
88. Signature of other		89. Signature of other		90. Signature of other	
91. Signature of other		92. Signature of other		93. Signature of other	
94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other	
100. Signature of other		101. Signature of other		102. Signature of other	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03464 CERTIFICATE OF DEATH 03457

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3206 Wellington Rd. d. STREET ADDRESS 3206 Wellington Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paul William LINDNER		4. DATE OF DEATH March 27 1962	
5. SEX Male	6. COLOR OR RACE Caucasion	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-78
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Elmont, L.I., N.Y.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George Lindner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 094 30 1168	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myelomonoblastic Leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) Pneumonia (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-23-62 to 3-27-62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 27 March 1962 , and that death occurred at 640 PM , from the causes and on the date stated above.			
22a. SIGNATURE W. F. Warrender M.D.		22b. DATE SIGNED March 28, 1962	
22c. PHYSICIAN'S NAME (Type) W. F. WARRENDER LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Smithtown		23d. LOCATION (City, town or county) (State) Smithtown L.I., NY.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Funeral Home, 7557 Wisc. Ave		25a. REC'D BY REGISTRAR MAR 30 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

08157

Virginia

Indemnity

Barbara (Mrs.)

U. S. Naval Hospital, Bethesda, Md.

Wagon

William

Paul

6-10-77

X

Concession

Male

U.S.A.

Barrett, A.I., N.Y.

Patent

Unknown

George Landner

Hospital Records

Case No 1103

No

First my husband's death
Barrett

X

3-27-82

1-23-82

27 March

March 28, 1982

U.S. Naval Hospital, Bethesda, Md.

U. S. WASHINGTON IN NO 1103

Barrett, A.I., N.Y.

Barrett

Barrett

Barrett, A.I., N.Y.

Barrett, A.I., N.Y.

Barrett, A.I., N.Y.

Barrett, A.I., N.Y. 100 Ave

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03465

03458

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Silver Spring</u> d. STREET ADDRESS <u>600 McNeill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Lindsey</u> Last <u>Lindsey</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1962</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-1896</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED COMMERCE COM. USGOV</u>				10b. KIND OF BUSINESS OR INDUSTRY 				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>James E. Lindsey</u>						14. MOTHER'S MAIDEN NAME <u>Mary J. Kirk</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 				17. INFORMANT Address <u>Belle H. Lindsey 600 McNeill Rd, Sil Sp., Md</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4-20-1</u> IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. } DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 											
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u> Month, Day, Year <u> </u> <u> </u> <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 				20f. (City or town) 		(County) 		(State) 			
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u>, to <u>March 5</u>, 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>March 1</u>, 19<u>62</u>, and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.																	
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>March 5, 1962</u>							
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr. M.D.</u>						22d. ADDRESS <u>9301 Coleville Rd., Silver Spring Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3-7-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Alexandria Virginia</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>						ADDRESS <u>4812 Ga Ave N.W., Wash. DC</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 9 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Myers</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed on 24 hours after death. Page 1 of 1. The law requires that the death certificate be executed on 24 hours after death. Page 1 of 1. The law requires that the death certificate be executed on 24 hours after death. Page 1 of 1.

08480

23308

(M)

(1)

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03466
CERTIFICATE OF DEATH

03459

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>12 yrs.</i>		16 <i>16</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1d. STREET ADDRESS <i>1869 Northampton</i>	
3. NAME OF DECEASED (Type or print) <i>Elfa. May Lodge</i>		4. DATE OF DEATH <i>Mar 29 1962</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 20 1877</i>	
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>John T. Conner</i>		14. MOTHER'S MAIDEN NAME <i>Mary Eliza Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>869 Northampton, Silver Spring, MD</i>	
17. INFORMANT <i>Mrs. M. K. Kunkel</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolism</i> DUE TO (b) <i>Cor. Fibrillation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>6 Mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3/17/1942</i> to <i>3/29/1962</i> that (I) (we) last saw the deceased alive on <i>3/27/1962</i> and that death occurred at <i>7 A</i> M, from the causes and on the date stated above.		22a. SIGNATURE <i>Howard T. Moore</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>3/29/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>Howard T. Moore</i>		22d. ADDRESS <i>7030 Carroll Ave Takoma Park Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 31, 1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Prince Geo. County, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i> ADDRESS <i>254 Carroll St NW Wash. DC</i>		25a. REC'D BY REGISTRAR DATE <i>APR 2 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

CERTIFICATE OF DEATH

1918

10000

[Faint, illegible text and markings on a form, likely a death certificate, with some handwritten notes and stamps.]

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03460

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KENSINGTON GARDENS SAN.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>12 Rockville Lane</u> d. STREET ADDRESS <u>6300 Tilden Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Reginald</u> Middle <u>B.</u> Last <u>Looker</u>		4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1962</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-73</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANK TELLER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>THOMAS H. Looker</u>		14. MOTHER'S MAIDEN NAME <u>L. Brigham</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>Spanish Amer</u>		16. SOCIAL SECURITY NO. <u>577-22-1999</u>		17. INFORMANT <u>Reginald B. Looker, Jr. - Son - same 2d</u> Address <u> </u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Diffuse bilateral pulmonary fibrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>cause undetermined</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 4, 1962</u> to <u>Mar 6, 1962</u> that (I) <u>(the)</u> last saw the deceased alive on <u>Mar 4, 1962</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.						
22a. SIGNATURE <u>George A. Gray, Jr.</u> M.D.		22b. ADDRESS <u>4940 Chevy Chase Dr. Ch. Ch. Md</u>		22c. DATE SIGNED <u>3/6/62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/8/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		24b. ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>		25b. REGISTRAR'S SIGNATURE <u> </u>

03450

CONTINUATION OF FORM

1-7407

(M)

0300 1100 1200

1100 1200

1200 1300

1300 1400

Yes

1100 1200

1200 1300

1300 1400

1400 1500

TO HOSPITAL DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03468

CERTIFICATE OF DEATH

03461

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Silver Spring</u>	
c. LENGTH OF STAY IN b. <u>4 days</u>		d. STREET ADDRESS <u>2425 Ross Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gordon Truett Lovett</u>		4. DATE OF DEATH <u>March 5 19 62</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 29, 1926</u>	
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Lovett</u>		14. MOTHER'S MAIDEN NAME <u>Ida Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>451-32-1501</u>	
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Diabetes Mellitus</u> DUE TO <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 years</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>March 1, 1962</u> to <u>March 5, 1962</u> that (I) (we) last saw the deceased alive on <u>March 5, 1962</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Samuel Barondes</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>March 8, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel Barondes, M.D.</u>		22b. DATE SIGNED	
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/9/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Memor. Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Amarillo, Texas</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>		25a. REC'D BY REGISTRAR <u>86 55 30, Ave.</u> DATE <u>MAR 12 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Silver Spring and</u>		25c. REGISTRAR'S SIGNATURE <u>Charles L. Haines</u>	

03181

03182



at least

i van spring

Reflected

The Chief Center, Richmond, Va.

avett

avett

avett

avett

avett

avett

avett

avett

avett

avett

avett

avett

avett

avett

avett

avett

avett

avett

avett

Handwritten notes at the bottom of the page, including "avett" and "avett" repeated multiple times.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03469
03462

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN lb 17 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG d. STREET ADDRESS Rt. 2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First SETH Middle HASKELL Last LOW		4. DATE OF DEATH Month 3-30 Day 62 Year 19		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-20-11		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-Biologist		10b. KIND OF BUSINESS OR INDUSTRY Wild Life		11. BIRTHPLACE (County & State, or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME RUSSELL C. LOW				14. MOTHER'S MAIDEN NAME ALICE KEITH PRESCOTT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215-36-3983		17. INFORMANT HOSPITAL RECORDS Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Pulmonary Embolus Astrocytoma of Rt Cerebrum INTERVAL BETWEEN ONSET AND DEATH 2 days 1450								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 3/13/62 3/30/62		(County) Prince George Co., Maryland	
21. I certify that (I) (this hospital) attended the deceased from 3/29/62 to 3/30/62, that (I) (we) last saw the deceased alive on 3/29/62 and that death occurred at 5:05A M, from the causes and on the date stated above.								22b. DATE SIGNED 3/30/62	
22c. PHYSICIAN'S NAME (Type) CHARLES H. LIGON, M.D.				22d. ADDRESS SANDY SPRING, MARYLAND		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-31-62		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) Prince George Co., Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE APR 3 '62		25b. REGISTRAR'S SIGNATURE	

WILLS

CERTIFICATE OF DEATH

1923

M

1

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

11-11-1923

Handwritten notes:
F. A. ...
...
...

3/12/23

12/10/23

3/10/23

JOHN ...

CHARLES ...

...

...

...

...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03470

03463

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville (rural)</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dover Rd</u>				d. STREET ADDRESS <u>Dover Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Luckett</u> Last <u>Luckett</u>				4. DATE OF DEATH Month <u>mar</u> Day <u>24</u> Year <u>1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>ew</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-2-1905</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John P. Luckett</u>				14. MOTHER'S MAIDEN NAME <u>Agnes N. Nelson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Arzella L. Clark (sister) Rockville md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration (left temporal lobe)</u> DUE TO <u>Fracture of skull</u> DUE TO <u>Struck by a blunt instrument</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Repeated struck with a hammer at home</u>			
20c. TIME OF INJURY Hour <u>3:55</u> a.m. <u> </u> Month, Day, Year <u>3-24 1962</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Rockville Montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>3-24-62</u>			
				Address (Street, city, town, or county) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National.</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 29 '62</u>			
ADDRESS <u>Rockville, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>			

00163

(M)

(1)

6/10/68

1

1 *2*

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 of this certificate are to be retained by the hospital or attending physician. TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03471
CERTIFICATE OF DEATH

03464

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN lb Maryland d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Hall Sanitarium		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admision) a. STATE Virginia b. COUNTY Arlington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 2411 N. Upshur Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JANE First E. MACDONALD Middle Last		4. DATE OF DEATH MARCH 12 1962 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) England	
13. FATHER'S NAME Thomas Martin Thompson		14. MOTHER'S MAIDEN NAME Emma Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Leone Robinson		Address 2411 N. Upshur St. Arlington, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 444X DUE TO Conditions, if any, which gave rise to immediate cause (b) ESSENTIAL HYPERTENSION (c), stating the underlying cause last. GENERALIZED ARTERIOSCLEROSIS DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 8 , 1961, to MARCH 12 , 1962, that (I) (we) last saw the deceased alive on MARCH 12 , 1962, and that death occurred at 1:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Henry Louden		22b. DATE SIGNED 3/12/62	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 5206 NORWAY DR. CHEVY CHASE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 3-13-1962	23c. NAME OF CEMETERY OR CREMATORY Beech Woods Cemetery	23d. LOCATION (City, town or county) (State) Beech Woods, Pa.
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler's Son		25. REGD BY REGISTRAR MAR 14 '62	
25b. REGISTRAR'S SIGNATURE Wm. S. Thomas			

00161

00161

Washington

Virginia

Montgomery

Albany

Kentington

2411 W. Dushar Street

Carroll Hall Building

19-20-1878

Female White

England

Housewife

James Brown

Thomas Martin Thompson

Leone Robinson

to

Paterson, N.J. Health Bureau

Essential Hypertension

Examination of Internal Organs

Sanity

Reed, Woods, Pa.

Report of the Board of Health



TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 1
TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03472

CERTIFICATE OF DEATH

03465

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG d. STREET ADDRESS Rt. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLIOTT GRANVILLE MACE First Middle Last 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12-18-01 9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 3 28 19 62		4. DATE OF DEATH Month Day Year 3 28 19 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARETAKER 10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA 11. BIRTHPLACE (County & State, or foreign country) U. S. A. 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME XXXXXX WILLIAM A. MACE 14. MOTHER'S MAIDEN NAME ANNA MC CLOUD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 232-030919 16. SOCIAL SECURITY NO. 232-030919 17. INFORMANT HOSPITAL RECORDS Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 5 days. years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 3/23 1962 3/28 1962		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 3/23 1962 to 3/28 1962 that (I) (we) last saw the deceased alive on 3/28 1962 and that death occurred at 3:32 P. from the causes and on the date stated above. 22a. SIGNATURE Richard A. Yates M.D. 22c. PHYSICIAN'S NAME (Type) RICHARD A. YATES, M.D. 22b. DATE SIGNED 3/29/62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS OLNEY, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3/30/62 23c. NAME OF CEMETERY OR CREMATORY Methodist 23d. LOCATION (City, town or county) (State) Clarksburg Md.		24. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville, Md. 25a. REC'D BY REGISTRAR DATE APR 2 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

03465

CERTIFICATE OF DEATH

02575

M

TO SIGN Y

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

Cause of Death

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03466

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF BIRTH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY <i>District of Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District of Columbia</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanatorium and Hospital</i>		d. STREET ADDRESS <i>6106 1st Place N.E.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Edmund S. Majchrzyk</i>		4. DATE OF DEATH Month Day Year <i>MARCH 25 1962</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>December 27, 1924</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>New York City</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Stanley Majchrzyk</i>		14. MOTHER'S M maiden NAME <i>Stella Kabat</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>Yes W.W. II</i>		16. SOCIAL SECURITY NO. <i>Nonnie Majchrzyk 6106 1st Place N.E.</i>	
17. INFORMANT <i>Nonnie Majchrzyk</i>		Address <i>6106 1st Place N.E.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MASSIVE THORACIC AND ABDOMINAL HEMORRAGE</i> 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>CRUSHED CHEST AND RUPTURED SPLEEN</i> DUE TO (c) <i>AUTO ACCIDENT</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>FRacture LEFT HIP AND LEFT LOWER LEG</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Driver of car involved in head-on collision</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>12:05 PM 3-25-1962</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i>		20f. (City or town) (County) (State) <i>Chillum P.G. Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschark</i>		DATE SIGNED <i>3-25-62</i>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschark</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		22b. DATE THEREOF <i>3/26/1962</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN CREMATORY</i>		22d. LOCATION (City, town, or country) (State) <i>PRINCE GEORGES COUNTY, MARYLAND</i>	
23. FUNERAL DIRECTOR <i>James E. Hyson</i>		24a. REC'D BY REGISTRAR <i>DAMAR 2 8 '62</i>	
HYSON'S FUNERAL HOME 1300 N. ST. N.W. - WASH. D.C.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03474

03467

1. PLACE OF DEATH a. COUNTY <u>Montg,</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>1 Yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg,</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1210 Crawford Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Exie</u> Middle <u>Salena</u> Last <u>Mann</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>16th</u> Year <u>1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 24-1879</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>22</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Lovettsville. Va,</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles K. Huff</u>				14. MOTHER'S MAIDEN NAME <u>Etta S. Cooper</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Lucille Graham. Rockville. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH <u>few months</u> <u>5 years</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 11</u> 19 <u>62</u> to <u>March 16</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>March 14</u> 19 <u>62</u> and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>W. H. Linticum</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/16/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. H. Linticum</u>				22d. ADDRESS <u>110 S. Washington St., Rockville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-19-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lovettsville Union</u>		23d. LOCATION (City, town or county) (State) <u>Lovettsville. Va.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

UNRECORDED

RECEIVED

1730

M

Investigation

Investigation

Investigation

Investigation

Investigation

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

(M)

Booths

2 days

John

The Clinical Center, Bethesda, Md.

The Clinical Center, Bethesda, Md.

Richard

Allen

Richard

John

John

John

John

John

John

John

John A. Green

John A. Green

The Clinical Center

The Clinical Center, Bethesda, Md.

The Clinical Center

The Clinical Center, Bethesda, Md.

2

John

John

John

John

John A. Green, III

John A. Green, III

The Clinical Center, Bethesda, Md.

John A. Green, III

John A. Green, III

CERTIFICATE OF DEATH

03469

03476

1. PLACE OF DEATH e. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>12 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>18604 Mayfair Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nina Mary Marinari</u>		4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1962</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-99</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>VINCENT</u>		14. MOTHER'S MAIDEN NAME <u>ROSE (UNKNOWN)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>PT's chart</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypertensive encephalopathy</u> 3-2-4 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3-22-62</u> to <u>3-22-62</u> , that (I) (we) last saw the deceased alive on <u>3-22-62</u> and that death occurred at <u>8:00 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John J. Merendino</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>John J. Merendino, M.D.</u>		22d. ADDRESS <u>Silver Spring, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-26-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City, town or county) <u>Washington, D.C.</u> (State)				
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Collins</u>		ADDRESS <u>4401 N. St.</u> <u>3821-14th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>EAR 27 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

1

ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03489

37373

(M)

420

12-17

1905 (1905)

12-17

12-17

12-17

12-17

12-17

12-17

12-17

TO REGISTERING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03477
03470
03477

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 8 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia b. COUNTY Jefferson c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Harpers Ferry d. STREET ADDRESS 85 x 13 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mayme Middle M. Last Marquette		4. DATE OF DEATH Month March Day 22 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/6/78
9. AGE (in years last birthday) 83 yrs.		10. IF UNDER 1 YEAR: Months 8 Days 22 Hours 15 Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Post Mistress U.S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Burleigh		14. MOTHER'S MAIDEN NAME Martha Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Correlia M. Jones - 6921 Strathmore St.		Address Ch. Ch., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma, Lungs and Liver DUE TO Primary undetermined Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 199 X (b) Primary undetermined (c) Primary undetermined		INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 e.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1959 to March 22 1962 that (I) (we) last saw the deceased alive on March 22 1962 and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Michael M. Healy		22b. DATE SIGNED 3/22/62	
22c. PHYSICIAN'S NAME (Type) Michel M. HEALY		22d. ADDRESS WASHINGTON CLINIC WASH, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/27/62	23c. NAME OF CEMETERY OR CREMATORY St. Peter's	
23d. LOCATION (City, town or county) Bolivar, W. Va.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Rockville, Md.		25e. REC'D BY REGISTRAR MAR 27 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Pinner			

0733

(M)

0733

83

Michael M. HEALY

March 3/2/64
1964
The White House

Director, FBI

TO HOSPITAL
death certificate be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
50
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03478
03471
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in 1b 745 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE New Jersey b. COUNTY Avenel, c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 67X-3 d. STREET ADDRESS 7 Manor Place			
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Josephine Marsh				4. DATE OF DEATH Month Day Year March 15, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 April 1893	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady				10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (County & State, or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Marsh				14. MOTHER'S MAIDEN NAME Madeline Mistler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No				16. SOCIAL SECURITY NO. Not available			
17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 467-2 CIRCULATING anticoagulant & massive left retroperitoneal hemorrhage, peritoneal, pleural (b) atelectasis left lung (c) necrosis left kidney 20 pressure from hematoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years 4 days 2 days 4 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from February 29, 1960, to March 15, 1962, that (X) (we) last saw the deceased alive on March 15, 1962, and that death occurred at 4:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Louis M. Aledort, M.D. M.D.				22b. DATE SIGNED March 16, 1962			
22c. PHYSICIAN'S NAME (Type) Louis M. Aledort				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial-transit		3-16-62		St. Gertrude's Cemetery		Colonia, New Jersey	
24 FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.			
25a. REC'D BY REGISTRAR DATE MAR 20 '62				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

03171

103

11

very

2

7

hon

7

7

7

7

7

of the

of the

of the

of the

of the

of the

from

from

from

from

of the

of the

of the

of the

of the

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any page is necessary, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03479 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03472

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN It <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>35 Silver Spring</u> d. STREET ADDRESS <u>4516 Randolph Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Robert</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>3/</u> Day <u>2/</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 17, 1938</u>	
9. AGE (In years last birthday) <u>23 yrs.</u>		10. IF UNDER 1 YEAR Months <u>23</u> Days <u>0</u>	
11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Edward Martin</u>		14. MOTHER'S MAIDEN NAME <u>Winifred Mae Redwine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>Navy 1955-1956</u>	
17. INFORMANT <u>Winifred Mae Crawford Mother</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 4-91X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral Broncho-pneumonia, acute</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
2Dc. TIME OF INJURY Hour <u>19</u> e.m. <u>0</u> p.m. <u>0</u>		2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Blaschke</u> EXAMINER'S NAME (Type) <u>FRANK J. BLASCHKE</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Mar 3 1962</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6 MAR 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON</u>		22d. LOCATION (City, town, or country) (State) <u>ARL VA.</u>	
23. FUNERAL DIRECTOR <u>Funeral Home</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

87139

87139



... ..

1

1

2

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03480

CERTIFICATE OF DEATH

03473

Item 5 Film G300 3/22/62 ink

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Silver Spring d. STREET ADDRESS 13106 Holdridge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDGAR J. MATTINGLY		4. DATE OF DEATH March 16, 1962	
5. SEX Male Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1882	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 1 Days 3 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Railroad		10b. KIND OF BUSINESS OR INDUSTRY Railroading	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Mattingly		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT 		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema. 522X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) Heart failure		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/16/62 , 19... to 3/16/62 , 19...; that (I) (we) last saw the deceased alive on 3/16/62 , 19... and that death occurred at 4:15 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Arthur Smith		22b. DATE SIGNED Mar. 16, 1962	
22c. PHYSICIAN'S NAME (Type) ASHBY W. SMITH		22d. ADDRESS 13018 Georgia Ave., Wheaton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 3-17-62	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town or county) (State) Reno, Nevada	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR MAR 20 '62	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

121

02430

02430

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

WATSON

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained at hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
03481
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
03474

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 44 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4700 Locust Hill Circle		d. STREET ADDRESS 4700 Locust Hill Circle	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First INEZ Middle MAYHEW Last		4. DATE OF DEATH Month March Day 23 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 11, 1874
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 5 Days 12 IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Barnesville, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Price		14. MOTHER'S MAIDEN NAME Mary Connor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter Mrs. Helen M. Lee		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week 7 YEARS 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis, chronic		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 30, 1954 to MAR. 23, 1962 that (I) (we) last saw the deceased alive on MARCH 17, 1962 and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert A. Angle, M.D.		22b. DATE SIGNED 3/23/62	
22c. PHYSICIAN'S NAME (Type) ROBERT A. ANGLE		22d. ADDRESS 5009 Del Ray Ave, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 3-23-62	
23c. NAME OF CEMETERY OR CREMATORY Dorset Cemetery		23d. LOCATION (City, town, or county) (State) Dorset, Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR MAR 27 '62		25b. REGISTRAR'S SIGNATURE C. L. P. Pumphrey	

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

00152

00152

one

one

one

one

one

one

one

one

one

one

one

one

one

one

one

one

one

one

one

one

one

one

James R. Canty

one

one

one

ROBERT A. FUMTERBY, Bethesda, Md.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 of 4
TO HOSPITAL: To be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

74

I

0

1

BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03483

CERTIFICATE OF DEATH

03476

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>8009-Piney Branch Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Willard L. McDaniel</u>				4. DATE OF DEATH Month Day Year <u>March 2 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/21/01</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobiles</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Wesley McDaniel</u>				14. MOTHER'S MAIDEN NAME <u>Clara Queen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>27546-4345</u>			
17. INFORMANT Address <u>James</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-20-0 Anterior myocardial infarction, acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 HOURS</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD</u>							
(c) <u>Pericardial tamponade collapse</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 2</u> , 19 <u>62</u> to <u>Mar 2</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Mar 2</u> , 19 <u>62</u> and that death occurred at <u>8:50 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip R. James</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3-6-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812-Jess. ave n.w.</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 8 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

05820

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03484					03477									
Item 14 Film G310 4/9/62 lwk														
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 705 Alvin Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Keith Brian Mc Grath					4. DATE OF DEATH Month MARCH Day 30 Year 1962									
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1961		9. AGE (In years last birthday) 9 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Montana			12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Kenneth Mazick Mc Grath					14. MOTHER'S MAIDEN NAME Myrna Campbell									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. -----					17. INFORMANT Hospital Records Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3312 Hemorrhage, Cerebral 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) ----- (a), stating the underlying cause last. DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----										INTERVAL BETWEEN ONSET AND DEATH 3 Days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -----									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		20g. (County) -----		20h. (State) -----				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 28 , 1962, to March 30 , 1962, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 30 , 1962, and that death occurred at 4:32 PM from the causes and on the date stated above.														
22a. SIGNATURE Lewis P. Scott					22b. DATE SIGNED APR 3 '62									
22c. PHYSICIAN'S NAME (Type) Lewis P. Scott LCDR MC USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-1-62		23c. NAME OF CEMETERY OR CREMATORY Parsons			23d. LOCATION (City, town or county) (State) Salisbury, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co.					25a. REC'D BY REGISTRAR DATE APR 3 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

1163

03477

03477

M

Q

1

Married

Married

Married

Married

Married (Married)

Married

Married

Married

Married

Married

Married

Married

USA

USA

Married

Married

Married

X

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

90

I

0

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03485
03478
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> <u>Kensington</u> <u>Maryland</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Messinger Gardens Sanatorium</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>VIRGINIA</u> b. COUNTY <u>NORFOLK</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PORTSMOUTH</u> <u>83X-3</u> d. STREET ADDRESS <u>1810 PRENTIS AVE</u> <u>3000 McComas Ave Norfolk, Va</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Delia</u>		First <u>F.</u> Middle <u>F.</u> Last <u>McHorney</u>		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18, 1870</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>W-S-V. Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Benjamin Luke Dundie II</u>					
14. MOTHER'S MAIDEN NAME <u>Frances Coleman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>George McHorney 9119 Bradford Rd, S.S., Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <u>420.0</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Congestive Heart failure</u> <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>2 mos.</u> <u>5 yrs.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>11</u> <u>1964</u> to <u>3/18/62</u> , that (I) (we) last saw the deceased alive on <u>3/18</u> <u>1962</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Donald Nelson</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/18/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Donad Donald Nelson</u>		22d. ADDRESS <u>11,128 Norlee Drive, Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-21-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Olive Branch Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Portsmouth Norfolk Virginia</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Z...</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>					
25. REC'D BY REGISTRAR <u>MAR 21 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>					

03478

RECEIVED

1947

M

APR 1947

SI 1947

RECEIVED

FOR THE

FOR THE

11, 1947

11, 1947

RECEIVED

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03479

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>20 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chandler Funeral Home</u>				d. STREET ADDRESS <u>13505 Olympic St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Andrew Paul McKay</u>				4. DATE OF DEATH Month Day Year <u>Mar 30 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 15 1895</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sgt. - Storage Co. - retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>Ind D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>William McKay</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Long</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Edith M. Stewart</u>			
17. INFORMANT <u>Edith M. Stewart</u>				Address <u>710 1st Ave Silver Spring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEIT</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-30-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>April 3-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	
23. FUNERAL DIRECTOR <u>Arthur Walters</u>				ADDRESS <u>254 Federal St</u>		24a. REC'D BY REGISTRAR <u>APR 3 '62</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur B. Thomas</u>	

03129

(M)

— William the King
— Richard King

Richard King
William the King

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03480
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03480

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <i>Va</i> b. COUNTY <i>Arlington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brookmont</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arlington</i>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <i>1313 N Hudson St</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Army Map Service 1600 Melburn Blvd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Bernard McKnee</i>		4. DATE OF DEATH <i>Mar 14 1962</i>	
5. SEX <i>male</i> COLOR OR RACE <i>white</i>		8. DATE OF BIRTH <i>8-28-1907</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>54</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Luther. Pressman</i>		11. BIRTHPLACE (State or foreign country) <i>DC</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Army map serv.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harry H. McKnee</i>		14. MOTHER'S MAIDEN NAME <i>Jessie Robertson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. INFORMANT <i>Army map Service records</i> Address	
16. SOCIAL SECURITY NO.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage + laceration</i> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>bullet wound thru skull</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Self inflicted bullet wound thru skull - 38 cal.</i>	
20c. TIME OF INJURY Month, Day, Year <i>10:20 a.m. 3-14 1962</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Army Map Serv</i>		20f. (City or town) <i>Brookmont Monty Md</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF <i>March 17, 1962</i>		DATE SIGNED <i>3-14-62</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Glenwood</i>		Address (Street, city, town, or county)	
22d. LOCATION (City, town, or country) <i>Washington, D.C.</i>		(State)	
23. FUNERAL DIRECTOR <i>Ives Funeral Home, Inc.</i> ADDRESS <i>Arlington, Virginia</i>		24a. REC'D BY REGISTRAR <i>W. L. 5 '62</i>	
<i>J. C. Gray</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. France</i>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

Sudden

Oct 30

200

(M)

(1)

March 17, 1902
Cherwood
Virginia

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03488

03481

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY in 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> d. STREET ADDRESS <u>4503 HIGHLAND AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LESLIE D. MEASELL</u> First Middle Last		4. DATE OF DEATH <u>MARCH 28 1962</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/27</u> Yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Leslie D. Measell SR.</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Reynolds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Army</u>		16. SOCIAL SECURITY NO. <u>577-28-9347</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma liver - metastatic</u> DUE TO <u>143X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>CARCINOMA, floor of work 24</u> DUE TO (c) <u>2</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-28-62</u> , 19 <u>55</u> , to <u>March 28, 1962</u> , that (I) (we) last saw the deceased alive on <u>3-28-1962</u> , and that death occurred at <u>7:35</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred S. Norton</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3/28/62</u>
22c. PHYSICIAN'S NAME (Type) <u>Alfred S. Norton</u>		22d. ADDRESS <u>Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/2/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 2 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>

18181

22222



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "London", "Birmingham", and "Manchester" are faintly visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03489 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03482

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10111 Brock Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida (NMN) Menick</u>		4. DATE OF DEATH Month Day Year <u>3 7 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-?-89</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zievel Kendal</u>		14. MOTHER'S MAIDEN NAME <u>Dina Rosenberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs Sylvia Resnick</u>		Address <u>10119 Brock Dr. S.S.M.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RIGHT CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>491X</u> DUE TO (b) <u>PULMONARY HEMORRHAGE, MASSIVE</u> DUE TO (c) <u>BRONCHOPNEUMONIA, ACUTE</u> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>SUDDEN</u> <u>DAYS, FEW</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>D.C. LODGE CEM.</u>		22d. LOCATION (City, town, or country) (State) <u>WASH., D.C.</u>	
23. FUNERAL DIRECTOR <u>Deedee Funeral Home</u>		ADDRESS <u>4217-9th Ave</u>	
24a. REC'D BY REGISTRAR <u>MAR 12 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(M)

(1)



00125

00125

Washington
1011
12-5-88

Russell
Dino Rosenbloom
was signed

...

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
03490
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03483

1. PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wheaton Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
		d. STREET ADDRESS 14 North Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Pawson Mider		4. DATE OF DEATH Month Day Year Mar. 27, 19 62	
5. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1871
9. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? Naturalized U.S.A.	
13. FATHER'S NAME George Pawson		14. MOTHER'S MAIDEN NAME Mary Broadley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Son Kenneth Mider		Address RD #1 Hornell, New York	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO lying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS UNDETERMINED	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/26/61 , 19... to 3/27 19 62 , that (I) (we) lost the deceased alive on 3/27 19 62 , and that death occurred at 3:45 PM from the causes and on the date stated above.			
22a. SIGNATURE John N. Tuohy M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Mar. 27, 1962	
22c. PHYSICIAN'S NAME (Type) JOHN N. TUOHY		22d. ADDRESS 7720 Wisconsin Ave., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/30/62	
23c. NAME OF CEMETERY OR CREMATORY Arkport Cemetery		23d. LOCATION (City, town, or county) (State) Steuben County, N. Y.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE MAR 28 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

03181

CENT HEAD OF TEETH

03181



1. Jaws

2. Jaws

3. Jaws

4. Jaws

5. Jaws

6. Jaws

7. Jaws

8. Jaws

9. Jaws

10. Jaws

11. Jaws

12. Jaws

13. Jaws

14. Jaws

15. Jaws

16. Jaws

17. Jaws

18. Jaws

19. Jaws

20. Jaws

21. Jaws

CHIEF

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 40 and over must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03491
03484
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY in lb 13 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE North Carolina b. COUNTY Jacksonville c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Howerton Apts. Apt. #7 d. STREET ADDRESS 70X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dale Robert Milks				4. DATE OF DEATH March 20, 1962			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 28, 1962	
9. AGE (In years last birthday) 1		IF UNDER 1 YEAR 1 Months 20 Days		IF UNDER 24 HRS. 1 Hours 20 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY Tenn.			
11. BIRTHPLACE (County & State, or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Richard Milks				14. MOTHER'S MAIDEN NAME Nancy Lawrence			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Hospital Records			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningomyelocele DUE TO Hydrocephalus Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 75102 DUE TO (b) Hydrocephalus DUE TO (c) Hydrocephalus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 7, 1962 , to March 20, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 20, 1962 and that death occurred at 8:05 PM from the causes and on the date stated above.							
22a. SIGNATURE Frederic A. Schulaner M.D.				22b. DATE SIGNED March 21, 1962			
22c. PHYSICIAN'S NAME (Type) Frederic A. Schulaner LT MC USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson-Wheeler Funeral Home, Rockville Pike,				25a. REC'D BY REGISTRAR MAR 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

2179

M

U. S. Naval Hospital
Bethesda (Dental)

Wife

Orlin

Richard Mink

No

Neurology

Hypertension

Robert
Mink
January 28, 1962
Tenn.

Hospital Records
Nancy Lawrence

Johnsville
North Carolina

Hospital Records

March 20, 1962

1

USA

March 1, 1962
8:00 PM

March 20, 1962

March 21, 1962

Frederic A. Schuman, MD MC USA U. S. Naval Hospital, Bethesda, Md.

Washington, Virginia

Washington, D.C.

3/23/62

Final

Hospital, Md.

Tyler-Hunter Funeral Home, Rockville, Md.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03492

CERTIFICATE OF DEATH

03485

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 1360 Peabody Street, N.W. Apt 4 e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edna Lorena Miller		4. DATE OF DEATH Month Day Year March 11 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1890
9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Months Days 12	11. IF UNDER 24 HRS. Hours Min. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi G. Nutt		14. MOTHER'S MAIDEN NAME Mary U. Armitage	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		18. The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage DUE TO 17 IX Condiions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute multiple gastric & duodenal ulcers DUE TO (c) Post op state total pelvic exenteration		INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of uterine cervix		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from February 23, 19 62 to March 11, 19 62 , that (X) (we) last saw the deceased alive on March 11, 19 62 , and that death occurred at 12:40 PM , from the causes and on the date stated above.		22a. SIGNATURE Yosef M. Pilch, M.D.	
22b. DATE March 11, 19 62		22c. PHYSICIAN'S NAME (Type) Yosef M. Pilch, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL, ETC. burial		23b. DATE THEREOF 3/14/62	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W., Wash, DC		25a. REC'D BY REGISTRAR MAR 14 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03493

CERTIFICATE OF DEATH

03486

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 hr. 20 min. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Silver Springs d. STREET ADDRESS 11900 Renick Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dorthea Middle Thelma Last Milne		4. DATE OF DEATH Month March Day 14 Year 19 62					
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1962	9. AGE (In years last birthday) yrs. 2	IF UNDER 1 YEAR Months 2 Days 20	IF UNDER 24 HRS. Hours 2 Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? -	
13. FATHER'S NAME George G. Milne III			14. MOTHER'S MAIDEN NAME Virginia Gerhold Poehlman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) Prematurity and Immaturity DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) - - - - - DUE TO (c) - - - - - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) - - - - -						INTERVAL BETWEEN ONSET AND DEATH -	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) - - - - -				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - -	20f. (City or town) - - - - - (County) - - - - - (State) - - - - -				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 14, 1962 to March 14, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 14, 1962 , and that death occurred at 6:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Frederic Schulaner M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> March 14, 1962		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) FREDERIC SCHULANER, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-20-62	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) Arlington, Virginia (State) -				
24. FUNERAL DIRECTOR'S SIGNATURE Tyson-Wheeler Funeral Home, Rockville Pike,		ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR MAR 19 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Hanna		

M

03403

03403

Bartholomew (Bartholomew)

U. S. Naval Hospital

Bartholomew (Bartholomew)

U. S. Naval Hospital

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

Bartholomew (Bartholomew)

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 236, Film G509 3/21/62 iwk

03488

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Louisiana</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bossier City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		d. STREET ADDRESS <u>2414 Arlington Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Joyce</u> Middle <u>Leigh</u> Last <u>Mitchell</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1961</u>
9. AGE (In years last birthday) <u>3</u> yrs. <u>13</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Louisiana</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Russell A. Mitchell</u>	
14. MOTHER'S MAIDEN NAME <u>Nannette Marshall</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>-----</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mother: Mrs. Nannette Mitchell, Same as #2</u> Address <u>-----</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> 754.5 DUE TO (b) <u>Anomalous Pulmonary Vein</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <u>Return</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo 13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>-----</u> p.m. <u>-----</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) <u>-----</u> (County) <u>-----</u> (State) <u>-----</u>	
21. I certify that (X) (this hospital) attended the deceased from <u>March 1, 1962</u> , to <u>March 14, 1962</u> that (X) (we) last saw the deceased alive on <u>March 14, 1962</u> , and that death occurred at <u>2:20 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>M. C. O'Bannon</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>March 15, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. C. O'BANNON, LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 19, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Paries</u>		23d. LOCATION (City, town or county) <u>Paries, Missouri</u> (State) <u>-----</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumpfrey</u> ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>-----</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>	
25c. DATE <u>MAR 19 '62</u>		25d. <u>-----</u>	

03188

208

M

(1911)

U. S. Navy

Johns

Washington

Louisiana

Resident

Comptroller of the Treasury
Department of the Treasury
Washington

McDonnell

U. S. Navy

Robert L. McDonnell

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 31 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY New York c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) New York d. STREET ADDRESS 21 East 90th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel (No middle name) Mittenenthal		4. DATE OF DEATH Month March Day 8 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 September 1909
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10	11. IF UNDER 24 HRS. Hours 9 Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Secretary		10b. KIND OF BUSINESS OR INDUSTRY Medical	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Rogatz		14. MOTHER'S MAIDEN NAME Rosebelle Alexander	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 710.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Scleroderma (c) 710.0 DUE TO Scleroderma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 710.0	
19. INTERVAL BETWEEN ONSET AND DEATH 5 minutes		20. INTERVAL BETWEEN ONSET AND DEATH 9 minutes	
21. INTERVAL BETWEEN ONSET AND DEATH 1 - 2 yrs.		22. INTERVAL BETWEEN ONSET AND DEATH 1 - 2 yrs.	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
24a. TIME OF INJURY Hour a.m. Month, Day, Year 19		24b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
25a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		25b. (City or town) (County) (State)	
26. I certify that I (this hospital) attended the deceased from Feb. 5 1962 to March 8 1962 , that I (we) last saw the deceased alive on March 6 8 1962 , and that death occurred at 9:35 A.M. from the causes and on the date stated above.			
27a. SIGNATURE Thomas Vates M.D.		27b. DATE March 8, 1962	
28a. PHYSICIAN'S NAME (Type) Thomas Vates		28b. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
29a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		29b. DATE THEREOF 3-9-62	
29c. NAME OF CEMETERY OR CREMATORY TEMPLE ISRAEL MT. HOPE		29d. LOCATION (City, town or county) (State) HASTINGS-N.Y.	
30. FUNERAL DIRECTOR'S SIGNATURE B. Danzandjtz		31. ADDRESS 3501-14th St NW	
32a. REC'D BY REGISTRAR MAR 13 '62		32b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03496

03489

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>138-Ritchie Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>HENRY</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-3-04</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, ever if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto mechanic</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robt. Joseph Moore</u>		14. MOTHER'S MAIDEN NAME <u>Reynolds</u> , First name-- <u>Bertha</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>145-076414</u>	
17. INFORMANT <u>Howard Donald Moore</u> Address <u>4913 40th Place, Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pulmonary Emphysema</u> DUE TO (c) <u>Chronic Pulmonary Fibrosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>20 years</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/22</u> <u>1962</u> to <u>3/26</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>3/26</u> <u>1962</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John E. Everett</u>		22b. DATE SIGNED <u>3/26/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		22d. ADDRESS <u>9400 Conn. Ave. Kensington</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-29-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland Prince George's Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Warner</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		25c. DATE <u>MAR 30 '62</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03497
03490
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgoery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kingston c. LENGTH OF STAY in lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Hall Sant.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 d. STREET ADDRESS 2744 Branbywine St. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM First MOORE Middle MOORE Last 4. DATE OF DEATH MARCH 7 1962 Month 7 Day 1962 Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Nov. 11, 1886 9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Safeway Store 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Va. 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Samuel H. Lightfoot 14. MOTHER'S MAIDEN NAME Mary A. Nelson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 578-12-0510 17. INFORMANT Mrs. Darnell Crain Jr. (Same AS 2D.) Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE (c) PARALYSIS AGITANS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Oct 10, 1959 to MARCH 7, 1962 that (I) (we) last saw the deceased alive on MARCH 7, 1962 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE William L. Louden M.D. 22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 5206 NORWAY CHEVY CHASE, MD 22b. DATE SIGNED 3/7/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF March 9, 1962 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill 23d. LOCATION (City, town or county) (State) Suitland Md.		25a. REC'D BY REGISTRAR MAR 9 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hume	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home ADDRESS Washington DC			

00190

Washington

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

00190

Washington

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

Nov. 11, 1986

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

03498
03491
M
I

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>11 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>105 Sunnyside Rd.</u></p>												<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>24 Silver Spring</u> d. STREET ADDRESS <u>105 Sunnyside Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>											
<p>3. NAME OF DECEASED (Type or print) <u>Martin Luther Moore</u></p>						<p>4. DATE OF DEATH <u>Mar 25 1962</u></p>																	
<p>5. SEX <u>male</u></p>		<p>6. COLOR OR RACE <u>white</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>9-6-1910</u></p>		<p>9. AGE (In years last birthday) <u>51</u> yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>													
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. to Genl. Sec.</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Treas.</u></p>				<p>11. BIRTHPLACE (State or foreign country) <u>Mo.</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>											
<p>13. FATHER'S NAME <u>Martin T. Moore</u></p>						<p>14. MOTHER'S MAIDEN NAME <u>Jessie Grayson</u></p>																	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u></p>				<p>16. SOCIAL SECURITY NO. <u>?</u></p>		<p>17. INFORMANT <u>Maryann Sullivan (wife) Strun 2</u> Address <u>Moore</u></p>																	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound into skull</u> DUE TO (c) <u>Sudden</u></p>												<p>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u></p>											
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>																							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound into skull</u></p>																			
<p>20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>noon p.m. 3-25 1962</u></p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, school, office bldg., etc.) <u>home</u></p>				<p>20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u></p>													
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>																							
<p>ACTUAL SIGNATURE <u>Frank J. Broschart</u></p>						<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>				<p>DATE SIGNED <u>3-25-62</u></p>													
<p>EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u></p>						<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>				<p>Address (Street, city, town, or county) <u>Washington, D.C.</u></p>													
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u></p>				<p>22b. DATE THEREOF <u>3/28/62</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Glennwood Cemetery</u></p>				<p>22d. LOCATION (City, town, or country) (State) <u>Washington, D.C.</u></p>													
<p>23. FUNERAL DIRECTOR <u>The S.H. Hines Company</u></p>						<p>ADDRESS <u>2901 14th St. N.W.</u></p>		<p>24a. REC'D BY REGISTRAR <u>MAR 27 '62</u></p>		<p>24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u></p>													

10450

8837

(M)

(T)

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03499

Items 8, 9 & 13 Film 0313 5/17/62 mh

03492

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>47X-3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens</i>		d. STREET ADDRESS <i>5420 Conn are NW</i>	
3. NAME OF DECEASED (Type or print) <i>Ruth</i> First <i>Z. MORELAND</i> Middle Last		4. DATE OF DEATH <i>March 19</i> 19 <i>62</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1888</i> <i>Apr. 23 1888</i>
9. AGE (In years last b. 37 yrs. <i>15</i>)		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Robert Arthur</i>		14. MOTHER'S MAIDEN NAME <i>Fannie Pyles</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Kensington gardens</i>	
17. INFORMANT <i>Kensington gardens</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerotic Heart Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Self</i> 1961 to <i>Mar 19</i> 1962 that (I) (we) last saw the deceased alive on <i>Mar 19 1962</i> and that death occurred at <i>8:30 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>R. Thibadeau</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>ROBERT T. THIBADEAU, M.D.</i>		22d. ADDRESS <i>10609 CONCORD ST. KENSINGTON, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>March 22-62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Seatons Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Summers Bros</i>		25a. REC'D BY REGISTRAR <i>Mar 21 62</i> DATE	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			

10000

10000

10000

(M)

(M)



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. (Page 4) be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03500				CERTIFICATE OF DEATH				03493					
Item 2 Film G311 4/17/62 mh													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u> c. LENGTH OF STAY IN 1b <u>3 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10131 Dallas Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>CHRISTIANA</u> Middle <u>MARGARETTA</u> Last <u>NEIL</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1962</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18, 1869</u>		9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Shelby Co. ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>George Christian Dichele</u>				14. MOTHER'S MAIDEN NAME <u>CHRISTIANA MARGARETTA METZGER</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Brooke Grove Foundation - Olney, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-43</u> DUE TO <u>BRONCHOPNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Cerebrovascular Accident</u> (c) <u>Hypertensive C.V. Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 mtd</u> <u>yrs</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>3/2</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>2/28</u> , 19 <u>62</u> , and that death occurred at <u>4:15</u> M., from the causes and on the date stated above. 22a. SIGNATURE <u>C.H. Hagan</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3/2/62</u> 22c. PHYSICIAN'S NAME (Type) <u>C.H. Hagan</u> 22d. ADDRESS <u>Sandy Spring, Md</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> 23b. DATE THEREOF <u>3-2-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Round Hill</u> 23d. LOCATION (City, town or county) (State) <u>Traphill, North Carolina</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u> 25a. REC'D BY REGISTRAR <u>WAR</u> 6 '62 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>													

03133

STATE OF TEXAS

03133

NOTICE

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03501
CERTIFICATE OF DEATH
03494

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>8 hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>41 Kensington</u>		d. STREET ADDRESS <u>3210 Blueford Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Claire</u> Middle <u>H.</u> Last <u>Nochera</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>19 62</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/10/98</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rose Gunning</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no.</u>				16. SOCIAL SECURITY NO. <u>Yes Unknown</u>			
17. INFORMANT <u>(Son) Thomas Hughes - same above</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>MAR 3</u> , 19 <u>62</u> to <u>MAR 3</u> , 19 <u>62</u> , that (we) last saw the deceased alive on <u>MAR 3</u> , 19 <u>62</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert G. Angle</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3/3/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>				22d. ADDRESS <u>Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/6/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				25a. REC'D BY REGISTRAR <u>MAR 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

1930

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03495

03502

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs 3 mo.</u>		d. STREET ADDRESS <u>1 916 G1ST. AVE.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Henry Nolte</u>		4. DATE OF DEATH Month Day Year <u>March 28 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 3, 1896</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY NOLTE</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH GLADMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>HELEN R. HAUGH</u> Address <u>916 G1ST AVE. (SISTER)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>24-1X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchial asthma</u> DUE TO <u>2-3 yrs.</u> (c) <u>2-3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Detention Encephalomalacia (old strokes)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> 19 <u>62</u> to <u>3/28</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3/27</u> 19 <u>62</u> and that death occurred at <u>8P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wisc. Av. Beth., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/31/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS</u>		23d. LOCATION (City, town, or county) (State) <u>FOREST GLEN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wu Chambers</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
ADDRESS <u>CO. WASHINGTON D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 30 '62</u>	

WITNESSES

JOHN WHITE

JOHN WHITE

WITNESSES
JOHN WHITE
JOHN WHITE

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03503
CERTIFICATE OF DEATH
03496

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN lb 8hrs. 10 min d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, d. STREET ADDRESS 1012 Henderson Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY BOY First Middle Last OWEN		4. DATE OF DEATH Month Day Year 3 - 17 1962	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-62
9. AGE (In years last birthday) 8		10. IF UNDER 1 YEAR Months Days 8 10	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) new born infant		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Richard Owen		14. MOTHER'S MAIDEN NAME Helen Kidwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. hospital records	
17. INFORMANT hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis 76200 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Pulmonary Edema DUE TO (c) Bilateral Adrenal Cortical Atrophy		INTERVAL BETWEEN ONSET AND DEATH At birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-17-1962 to 3-17-1962 that (I) (we) last saw the deceased alive on 3-17-1962 and that death occurred at 8:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		22b. DATE SIGNED 3-19-62	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher		22d. ADDRESS Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/21/62	23c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery	23d. LOCATION (City, town or county) (State) Boys, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Lyson Wheeler ADDRESS Rockville, Maryland		25a. REC'D BY REGISTRAR DATE MAR 22 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2-052285

14

MONTGOMERY

MARYLAND

MONTGOMERY

OLNEY

SPR. 10 MI.

Silver Spring,

Montgomery General Hospital

1015 Henderson Avenue

BABY BOY

OWENS

3 - 17

02

White

3-17-62

8 10

New born infant

Montgomery, Maryland, U.S.A.

William Richard Owens

Helena Kidwell

Hospital records

no

Jack Schmanor

Galtersburg, Md.

CERTIFICATE OF DEATH

03497

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE District Of Columbia f. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1914 Connecticut Ave., N.W. 47X-3 g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Zelma Alexandra Ozols First Middle Last		4. DATE OF DEATH March 14, 1962 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1902 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		10b. KIND OF BUSINESS OR INDUSTRY Library	
11. BIRTHPLACE (County & State, or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Bergmanis		14. MOTHER'S MAIDEN NAME Emilie Kavpul	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 579-42-0889	
17. INFORMATION The Medical Records		The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage into L. Hemithorax DUE TO 203X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aplastic anemia DUE TO (c) Multiple myeloma INTERVAL BETWEEN ONSET AND DEATH 5 days 18 months 18 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from September 13, 1961 to March 14, 1962 that (I) (we) last saw the deceased alive on March 14, 1962 and that death occurred at 8:35 PM from the causes and on the date stated above.			
22a. SIGNATURE Marvin Lewis M.D.		22b. DATE SIGNED March 15, 1962	
22c. PHYSICIAN'S NAME (Type) Marvin Lewis, M.D.		22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL TO CHURCH, etc.	23b. DATE THEREOF 3/17/62	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City, town or county) (State) Washington, D.C.
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.		25a. REC'D BY REGISTRAR MAR 19 62 DATE	
		25b. REGISTRAR'S SIGNATURE Caribut L. Hines	

MEDICAL CERTIFICATION

TO HO...
death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



one copy

Revised

The Clinical Center, Bethesda, Md.

John

Alexander

Quora

March 11

female white

x

July 2, 1902

59

Library on

Library

Levia

E.S.S.

Alexander, Benjamin

White House

The National Records

72-42-0882 The Clinical Center, Bethesda, Md.

NO

Revised (see 1. 1902)

5 days

clinical studies

clinical studies

September 12, 1902

62

March 11

Revised

John Lewis, M.D.

The Clinical Center, National
Institution of Health, Bethesda, Md.

Washington, D.C.

Rock Creek Cemetery

Wash., D.C.

The S. H. H. Co., 2501 14th St. N.W.

03197

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03505

03498

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 63 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. (D. C.) b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Washington d. STREET ADDRESS 5626 Massachusetts Avenue NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wendell Anthony Parker		4. DATE OF DEATH Month Day Year March 20, 19 62	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1907
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M.D.		10b. KIND OF BUSINESS OR INDUSTRY - - - -	
11. BIRTHPLACE (County & State, or foreign country) Lakewood, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wendell Parker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		16. SOCIAL SECURITY NO. Hospital Records	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, stomach DUE TO 1 SIX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from Jan. 15, 1962 to March 20, 1962 that it (we) last saw the deceased alive on March 20, 1962 , and that death occurred at 5:45 AM from the causes and on the date stated above.			
22a. SIGNATURE John W. Brackett Jr. M.D.		22b. DATE SIGNED March 20, 1962	
22c. PHYSICIAN'S NAME (Type) JOHN W. BRACKETT JR.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-23-62	23c. NAME OF CEMETERY OR CREMATORY Arlington National Bethesda, Md.	23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		25a. REC'D BY REGISTRAR MAR 22 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

00000

Washington

Richards (Rosal)

U. S. Naval Hospital

Weddell

Chapman

Milo

M.D.

Wendell Parker

Yes

D. C.

Washington

3030 Massachusetts Avenue NW

Parker

May 10, 1907

Lakewood, Ohio

Unknown

Hospital Records

Caroline, et al.

John W. Brockett Jr.

JOHN W. BROCKETT JR.

Washington National

Richards, Md.

Robert W. Anthony Funeral Home, 1557 Lee Ave.

Washington, Virginia

U. S. Naval Hospital, Bethesda, Md.

Jan. 15, 05

March 20, 05

March 20, 05

March 20, 1905

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03506

03499

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>917 Dale Drive</i>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth Peterson</i>		4. DATE OF DEATH <i>March 1 1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/2/81</i>
9. AGE (in years last birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>HARLAN IOWA</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John O. Michaelson</i>	
14. MOTHER'S MAIDEN NAME <i>MARTINE NELSON</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>None</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Alice P. Berger</i> Address <i>917 Dale Dr, Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Arteriosclerosis</i> (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 26</i> , 19 <i>62</i> , to <i>March 1</i> , 19 <i>62</i> , that (I) (we) last saw the deceased alive on <i>March 1</i> , 19 <i>62</i> , and that death occurred at <i>10:00</i> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward J. Richards</i> M.D.		22b. DATE SIGNED <i>3-1-62</i>	
22c. PHYSICIAN'S NAME (Type) <i>Edward J. Richards</i>		22d. ADDRESS <i>10,110 Georgia Ave, Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-5-62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Congressional Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Ziska</i> ADDRESS <i>34 Georgia Ave, Silver Spring, Maryland</i>		25. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc.</i> DATE <i>5 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinn</i>			

03189

03189

(M)

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03507

03500

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY in lb 57 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5605 Albia Road		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5605 Albia Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMILIE Middle PORTO Last PORTO		4. DATE OF DEATH Month March Day 19 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Italy	9. AGE (In years last birthday) 67 yrs. 11. BIRTHPLACE (County & State, or foreign country) USA-Nat.
13. FATHER'S NAME Albert Musacchio		14. MOTHER'S MAIDEN NAME Salmoa Cavalieri	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Son Joseph B. Porto Address Same as Item 2.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Cardio-Vascular Renal Sclerosis DUE TO (c) Diabetes Severe Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 yrs + 5 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1960 19 to March 19, 1962 that (I) (we) last saw the deceased alive on March 19, 1962 , and that death occurred at 12:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. J. D. Damian M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Mar. 19, 1962
22c. PHYSICIAN'S NAME (Type) Jules D. Damian		22d. ADDRESS 2741 - 34th St., N.W., Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE THEREOF 3/22/62	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum	23d. LOCATION (City, town or county) (State) Prince George Co. Md.
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR Mar 22 '62	25b. REGISTRAR'S SIGNATURE Arthur L. Thomas



13505

CENTRAL OF GREAT

13500

Montgomery

Montgomery

Montgomery

Bellevue

Bellevue

5005 Alpha Road

5005 Alpha Road

WHITE

WHITE

WHITE

Female White

Female White

Female White

Housewife

Housewife

Albert Francisco

Albert Francisco

None

Joseph B. Porto

Same as item 1.

John D. Larkin

John D. Larkin

13505

13505

Robert A. Bunnell

Robert A. Bunnell

Robert A. Bunnell

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be examined in 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03508
CERTIFICATE OF DEATH

03501

1. PLACE OF DEATH e. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 26 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 1 6400 Stratford Rd.;		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Erma S. Potts		4. DATE OF DEATH March 20 19 62		5. SEX FEMALE	
6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-18-94	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ROBERT SHADE		14. MOTHER'S MAIDEN NAME VIRGINIA UNGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO NO		16. SOCIAL SECURITY NO. Mrs G.C. Williams 12807 Flack St. Sil Sp.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Adenocarcinoma with metastases, primary site undetermined		19. INTERVAL BETWEEN ONSET AND DEATH 3 months		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Winchester, Virginia		20g. (County) Winchester, Virginia		20h. (State) Winchester, Virginia	
21. I certify that (I) (this hospital) attended the deceased from 2/18/62, 12 to 3/20/62, 1962, that (I) (we) last saw the deceased alive on March 20, 1962, and that death occurred at 4:45 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Robert N. Coale		22b. DATE SIGNED March 20, 1962		22c. PHYSICIAN'S NAME (Type) Dr. Robert N. Coale	
22d. ADDRESS 4429 Bradley Lane, Bethesda.		22e. REC'D BY REGISTRAR MAR 27 '62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/62		23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery	
23d. LOCATION (City, town or county) Winchester, Virginia		23e. REC'D BY REGISTRAR MAR 27 '62		23f. REGISTRAR'S SIGNATURE Arthur L. Krause	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland					

03201

3-03



1

Robert A. Humphrey, Bethesda, Maryland
Mr. Harmon Stearns, Washington, Virginia

Mr. and Mrs. John

Miss Emily

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03509
CERTIFICATE OF DEATH
03502

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY in 1b 199 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE California		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Los Angeles		d. STREET ADDRESS 1011 1/4 S. Harvard Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Morris Edward Queen		4. DATE OF DEATH Month Day Year March 14, 1962		5. SEX Male		6. COLOR OR RACE Negroid		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1937		9. AGE (In years last birthday) 24 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Service Man		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James H. Queen		14. MOTHER'S MAIDEN NAME Mary A. Barnes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Granulocytic leukemia 204-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Aug. 27, 1961 to March 14, 1962, that (X) (we) last saw the deceased alive on March 14, 1962, and that death occurred at 7:10 AM from the causes and on the date stated above.		22a. SIGNATURE Joseph E. Stitcher M.D.		22b. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22c. PHYSICIAN'S NAME (Type) JOSEPH E. STITCHER LCDR MC USN		22d. DATE SIGNED March 14, 1962		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-21-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE JOHNSON & JENKINS FUNERAL HOME, 4804 Ga. Ave.		25a. REC'D BY REGISTRAR DATE MAR 20 '62		25b. REGISTRAR'S SIGNATURE C. L. H. H.		25c. REC'D BY REGISTRAR DATE		25d. REGISTRAR'S SIGNATURE		25e. REC'D BY REGISTRAR DATE		25f. REGISTRAR'S SIGNATURE		25g. REC'D BY REGISTRAR DATE		25h. REGISTRAR'S SIGNATURE	

(M)

(J)

00203

(Jury)

U. S. Court

1900

James H. Brown

James H. Brown

Yes

00203

(Jury)

U. S. Court

1900

James H. Brown

James H. Brown

Yes

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

00203

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

James H. Brown

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
035110					03503									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY							
Montgomery Co.		27 hrs.			Maryland		Montgomery							
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS							
Olney		Montgomery General Hospital			Rockville		5910 Ridgway Ave.							
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last					Month Day Year									
William James Baby Boy Ray					Mar. 3 19 62									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs. Months Days						
male		white				3/2/62		1 1						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
						Montgomery Gen. Hosp. USA								
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Robert S. Ray					Barbara Tough									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address								
no				Hospital Records										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
754.2 DUE TO Congenital Heart Disease														
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.														
DUE TO Interventricular Septum Defect - Incomplete relation of aorta														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).														
Situs Inversus (Complete)														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										
21. I certify that (I) (this hospital) attended the deceased from 3/2 12 to 3/3 12, 19 62, that (I) (we) last saw the deceased alive on 3/3 12, and that death occurred at 3/3 12 M, from the causes and on the date stated above.														
22a. SIGNATURE					22b. DATE SIGNED									
Dr. C.H. Ligon					3/4/62									
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
					Sandy Spring, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)								
Burial		3/6/62		Parklawn		Rockville, Maryland								
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Lyon Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland					DATE MAR 8 '62					Arthur L. Harris				

2-052257

(M)

02520

Montgomery Co.

Olney

27 hrs.

Rockville

3910 Ridgeway Ave.

Montgomery General Hospital

Emergency

RAY

3/2/62

white

male

Montgomery Gen. Hosp.

Barbara Trough

Robert E. Ray

Hospital Records

no

Dr. C. H. Ligon

TO HOSPITAL: The law requires that the death certificate be examined in 24 hours after death. Page 1 of 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
03511													
03504													
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 Silver Spring d. STREET ADDRESS 607 Dartmouth Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) James Gordon Reidinger						4. DATE OF DEATH Month March Day 27 Year 19 62							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 23, 1919		9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent				10b. KIND OF BUSINESS OR INDUSTRY Northwood High School Maintenance				11. BIRTHPLACE (County & State, or foreign country) Anniston, Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Gordon M. Reidinger						14. MOTHER'S MAIDEN NAME Saidie Scheid							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 23-07-0122 -Unavailable-						17. INFORMATION The Medical Record	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart failure DUE TO (c) Chronic Glomerulonephritis INTERVAL BETWEEN ONSET AND DEATH 24 hours Undetermined Undetermined													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (H) (this hospital) attended the deceased from March 21, 1962 to March 27, 1962 that (U) (we) last saw the deceased alive on March 27, 1962 and that death occurred at 5:20 A.M. from the causes and on the date stated above.													
22a. SIGNATURE Norman H. Bell M.D. M.D.						22b. DATE SIGNED March 27, 1962							
22c. PHYSICIAN'S NAME (Type) Norman H. Bell, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-62		23c. NAME OF CEMETERY OR CREMATORY Highland Cemetery				23d. LOCATION (City, town or county) (State) Anniston Calhoun Co, Alabama					
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zisk Warner E. Pumphrey, Inc., Silver Spring, Maryland						25a. REC'D BY REGISTRAR MAR 29 62 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Hume							

03504

03504

Anthony

Wynland

Anthony

Silver Spring

6 days

Anthony

509 Lantana Avenue

The Clinical Center, Bethesda, Md.

x

03

03

March

Reidinger

Gordon

James

November 23, 1973

White

White

V.S.A.

Alabama

Alabama

Alabama

Alabama

Alabama

The Medical Record

1973

The Clinical Center, Bethesda, Md.

March

March



March

03

March 27

03

March 27

03

March 27

March 27, 1973

The Clinical Center, National Institutes of Health, Bethesda, Md.

March 27, 1973

March 27, 1973

March 27, 1973

March 27, 1973

March 27, 1973

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03512

CERTIFICATE OF DEATH

03505

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>	
c. LENGTH OF STAY IN 1b <u>34-10 mos 26 dy</u>		d. STREET ADDRESS <u>128 South Adams Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Rice</u> Last <u>Rice</u>		4. DATE OF DEATH Month <u>MAR</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 18 1869</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>music teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George R. Rice</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Ischiffsky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Julia M. Walter-Neice-Wash.</u>		Address <u>D. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized & cerebral arteriosclerosis</u> DUE TO (c) <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10+ years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 4 1958</u> to <u>March 14 1962</u> , that (I) (we) last saw the deceased alive on <u>March 7 1962</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>G. Bowditch Hunter, Jr.</u> M.D.		22b. DATE SIGNED <u>Mar. 14, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter, Jr., M.D.</u>		22d. ADDRESS <u>809 Veirs Mill Rd., Rockville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Darnestown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	
ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 16 '62</u>	

M

00112

CERTIFICATE OF LEAD

00302

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03513

CERTIFICATE OF DEATH

03506

Item 23b Film G310 4/2/62 mh

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

5 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Adelphi

1673-2

d. STREET ADDRESS

10506 Edgemont Dr.

a. IS RESIDENCE ON A FARM?

YES ☐ NO ☐

3. NAME OF DECEASED

(Type or print)

First

Stanley

Middle

Schreiber

Last

Ricker

4. DATE OF DEATH

Month

March

Day

25

Year

1962

5. SEX

Male

6. COLOR OR RACE

Caucasian

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

February 3, 1919

9. AGE (In years last birthday)

43 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Naval Officer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert B. Ricker

14. MOTHER'S MAIDEN NAME

Lena Perry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

Yes

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

WIFE: Mrs. Pauline F. Ricker Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Hepatic failure

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO

1. 53.8
Hemorrhagic Peritoneal Effusion
Metastatic Carcinoma of Colon
4 years

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

22c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

22d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from March 21, 1962, to March 25, 1962, that (I) (we) last saw the deceased alive on March 25, 1962, and that death occurred at 0650 from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

WILLIAM P. BAKER LT MC USN

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

March 25, 1962

22b. DATE SIGNED

22d. ADDRESS

U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

Mar. 28, 1962

23c. NAME OF CEMETERY OR CREMATORY

NATIONAL CEMETARY

23d. LOCATION (City, town or county)

ARLINGTON, VA.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

S.H. HINES CO. FUNERAL HOME 2901 14TH ST NW WDC

25a. REC'D BY REGISTRAR

MAR 27 '62

25b. REGISTRAR'S SIGNATURE

Arthur L. Thomas

VR A15 (4)

15M 7/61

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be examined in 24 hours after death. Page 1 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03200

03213



AND

Washington, D. C.

United States

Department of the Interior

General Land Office

Washington, D. C.

Handwritten text, likely a signature or title, mostly illegible due to fading.

ILLIAM P. HANCOCK JR. NO. 1234

WASHINGTON, D. C.

U. S. DEPARTMENT OF THE INTERIOR

GENERAL

U. S. DEPARTMENT OF THE INTERIOR

03514

CERTIFICATE OF DEATH

Reg. Dist. No. 23507

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. (If institution, state name of institution.) a. STATE MARYLAND b. COUNTY PRINCE GEORGES MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 17 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM & HOSPITAL		e. STREET ADDRESS 6618 Poplar Avenue	
3. NAME OF DECEASED (Type or print) First NELLIE Middle ROSE Last ROBERTSON		4. DATE OF DEATH Month 3 Day 31 Year 19 62	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-85
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	11. IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON, D. C.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christian Keiner		14. MOTHER'S MAIDEN NAME Caroline (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Kenneth R. Robertson		Address 6109 Wilmett Rd. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Coronary Thrombosis - Cardiac Failure DUE TO (2) Chronic Coronary Arteriosclerosis DUE TO (3) Arterial Hypertension DUE TO (4) Indeterminate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteo-Arthritis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1, 1952 to Mar 31, 1962 that I last saw the deceased alive on Mar 31, 1962 , and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Sigma Camp Rd. Silver Spring, Md. DATE SIGNED Mar 31, 1962			
ACTUAL SIGNATURE George L. Ball M.D.		PHYSICIAN'S NAME (Type) George L. Ball Silver Spring Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-3-1962	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collier		24a. REC'D BY REGISTRAR Wash. D. C.	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
DATE APR 4 '62			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSTESS: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

M

73

I

0

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03515						03508					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
e. COUNTY			Montgomery			e. STATE			b. COUNTY		
			MARYLAND						Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Ciney			1 week			Gaithersburg					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
Montgomery General Hospital						RFD # 1, Box 193B			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. YEAR		
First Middle Last						Month Day Year					
Charles Augustus Robinson						March 5			1962		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR	
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov. 17, 1882		79		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Architect								Salamanca, N.Y.		USA	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
George Henry Robinson						Jessie Crocker					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				276-16-5311		Miss Alice L. Robinson, Item 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										1 week.	
4 4 X DUE TO Advanced cerebral arteriosclerosis with											
(b) multiple thrombi and endophthalomacia										5 years	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.											
DUE TO Severe arteriosclerotic cardio-vascular-renal disease.											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED?	
Diabetes Mellitus										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
				No injury							
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour e.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 1954 to March 5, 1962, that (I) (we) last saw the deceased alive on March 5, 1962, and that death occurred at 5:20AM from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
M. McKendree Boyer, M. D.									3/5/62		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
M. McKendree Boyer, M. D.						9830 Main Street Damascus, Maryland.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
Burial		3/8/62		Acacia Park Cemetery		Mayfield Heights, Ohio.					
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Olin L. McBurneth						Damascus, Md.		DATE MAR 7 '62		Arthur L. Kraus	



80250

2259

14
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MONTGOMERY MARYLAND											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE b. COUNTY							
Montgomery				Md. Mont. Co.							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
Bethesda				27 hrs 5 mins X				Kensington			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Suburban				11107- Newport Mill Rd.							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				5. SEX			
First Middle Last				Month Day Year				Male Female			
Carmela Motta Romeo				March 16 19 62				Female			
6. COLOR OR RACE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
White				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				4/9/1900			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				9. AGE (In years last birthday)			
Housewife								61 yrs.			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
CATANIA ITALY				USA				ANTONIA MOTTA			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
GRAZIA CHITE											
17. INFORMANT				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
Joe Romeo. 11107 Newport Mill Rd.				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812X DUE TO Pulmonary embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple fracture (c) Ran over by auto				sudden 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian - Ran over by own car							
20c. TIME OF INJURY Month, Day, Year Hour 12:05 p.m. 3-15-1962				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) driveway			
20f. (City or town) Kensington				20g. (County) Montg				20h. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
ACTUAL SIGNATURE Frank J. Broschert				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Broschert				Address (Street, city, town, or county)				MAR 17, 1962			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY			
Burial				20 MAR 1962				St. Lincoln Mausoleum, PR Geo City Md.			
23. FUNERAL DIRECTOR				ADDRESS				24a. REC'D BY REGISTRAR			
RINALDI FUNERAL HOME 7400 CA AVE NW				NASH DC.				24b. REGISTRAR'S SIGNATURE			
				DATE MAR 21 '62				Arthur L. Kline			



013520

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03517 CERTIFICATE OF DEATH 03510

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4806 Middlesex Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alfio Ronsisualle</u>		4. DATE OF DEATH Month Day Year <u>March 14 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1888</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barbering</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Ronsisualle</u>		14. MOTHER'S MAIDEN NAME <u>Concetta Emanuele</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-18-4013</u>	
17. INFORMANT <u>Maria (wife)</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Ruptured Diverticulum, sigmoid colon</u> (c) <u>Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 4</u> , 19 <u>62</u> to <u>Mar 14</u> , 19 <u>62</u> that (I) (<u>we</u>) last saw the deceased alive on <u>Mar 14</u> , 19 <u>62</u> and that death occurred at <u>8:34 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John P. Haberman</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Mar 14 1962</u>
22c. PHYSICIAN'S NAME (Type) <u>John P. Haberman</u>		22d. ADDRESS <u>1015 Spring St Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/17/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>Mar 16 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>	

08510

08510

14

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page.]

John P. Haver
John P. Haverline
2/17/02
Robert A. Hughes, Bethesda, Maryland
Silver Spring, Maryland
2/17/02

TO HOSPITAL
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
The law requires that the death certificate be executed within 24 hours after death.
Page 4
VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03518 Items 1c, 7 & 14 Film 3309 5/29/62 1wk 03511											
1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.						d. STREET ADDRESS 5901 Simmonds Avenue					
3. NAME OF DECEASED (Type or print) First David Middle N Last Rudin						4. DATE OF DEATH Month March Day 18 , Year 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH December 3, 1905		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 3 Days 01	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (County & State, or foreign country) Russia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Nisson Rudin						14. MOTHER'S MAIDEN NAME Pauline (last name unknown) Zeldin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WW II				16. SOCIAL SECURITY NO. 448-26-1018		17. INFORMANT Address The Medical Records The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary infarction DUE TO Multiple myeloma Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 18 Hours 3 Years											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from October 4, 1960 to March 18, 1962 that (I) (we) last saw the deceased alive on March 18, 1962 , and that death occurred at 5:05 PM from the causes and on the date stated above.											
22e. SIGNATURE J. L. Fahey M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/18/62			
22c. PHYSICIAN'S NAME (Type) John L. Fahey M.D.						22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 19, 1962		23c. NAME OF CEMETERY OR CREMATORY Beth Tfiloh Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS. INC. 6010 Reisterstown Rd.						25a. REC'D BY REGISTRAR MAR 20 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

M

SGT LEVINSON & SONS, INC. 6010 Rockwood Rd.

March 19, 1952 South Tarrant County

Baltimore, Maryland

John J. Haney, Jr.

Institution of Health, Bethesda, Md.

March 18, 1952

October 1, 1950

March 18, 1952

3/18/52

Multiple systems

acute primary infection

12 years

3 years

Yes

10-20-1948

The Clinical Center, Bethesda, Md., Maryland

The Medical Records

Blason Rubin

Medicine

Rosalia

U.S.A.

White

December 3, 1902

Indian

March 18, 1952

Levin

The Clinical Center, Bethesda, Md., Md.

Self diagnosis

His legs

Baltimore

Montgomery

Montgomery

Baltimore

03511

03511

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03519 CERTIFICATE OF DEATH 03512

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
3. NAME OF DECEASED (Type or print) First James Middle V. Last Sammartino		4. DATE OF DEATH Month March Day 24th Year 1962		b. COUNTY Montgomery	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/24/89		9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.-Air Plane Parts Plant	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Vincent Sammartino	
14. MOTHER'S MAIDEN NAME (Unknown)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 103-14-4621	
17. INFORMANT Daughter Mrs. Alberta Linn		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive Heart Failure Coronary Arteriosclerotic Ht. Disease - Myocard. Infarction - 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> et work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from December 1960 to March 24, 1962 that (I) last saw the deceased alive on March 24, 1962, and that death occurred at 9:40 M, from the causes and on the date stated above.					
22a. SIGNATURE James W. Egan		22b. DATE 3-25-62		22c. PHYSICIAN'S NAME (Type) Dr. James W. Egan	
22d. ADDRESS 9911 Old Spring Rd., Kensington, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE 3-25-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 3-26-62		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION (City, town or county) Lawrence, New York		23e. REC'D BY REGISTRAR DATE MAR 27 '62		23f. REGISTRAR'S SIGNATURE Arthur S. Hanna	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.			

03212

03212

(M)

103-14-1031

ROBERT A. PHILLIPS, Secretary, New York

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03520		Items 1c, & 2 Film G308 3/12/62				03513					
1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Wash. D.C. f. COUNTY Montgomery							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 46 years-3 months				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville/ Washington, D.C.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chestnut Lodge				d. STREET ADDRESS unknown 500 W. Montgomery Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGUERITE				First Middle Last SAWYER				4. DATE OF DEATH March 2, 1962 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ? 1874		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Lucius Sawyer				14. MOTHER'S MAIDEN NAME Elizabeth M. Ricker							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 450.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO General arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 7/1/1961, to 3/2/1962, that (I) (we) last saw the deceased alive on 2/21/1962, and that death occurred at 8 p.m. from the causes and on the date stated above.											
22a. SIGNATURE Dexter M. Bullard				M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Mar. 3, 1962			
22c. PHYSICIAN'S NAME (Type) DEXTER M. BULLARD, M.D.				22d. ADDRESS Falls Rd., Rockville, Maryland.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF March 7, 1962		23c. NAME OF CEMETERY OR CREMATORY Rock Creek		23d. LOCATION (City, town or county) (State) Washington, D.C.					
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home				ADDRESS 1331 E. Montg. Ave Rockville, Maryland		25a. REC'D BY REGISTRAR DATE MAR 8 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

03250

03250



[Faint, mostly illegible text covering the majority of the page, appearing to be a document or form.]

TO HOSPITAL: The law requires that the death certificate be executed on 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03521

03514

1. PLACE OF DEATH e. COUNTY Montgomery f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda g. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Illinois b. COUNTY Peoria c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Peoria d. STREET ADDRESS 6918 North Wilshire Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph William Schmitt		4. DATE OF DEATH March 27, 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1920
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11b. KIND OF BUSINESS OR INDUSTRY Contractor	
11c. BIRTHPLACE (County & State, or foreign country) Illinois		11d. CITIZEN OF WHAT COUNTRY? U.S.A.	
12. FATHER'S NAME Henry Aaron Schmitt		13. MOTHER'S MAIDEN NAME Jennie Decker	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		15. SOCIAL SECURITY NO. 329-12-7789	
16. INFORMANT The Medical Records		17. ADDRESS The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple focal hemorrhages in brain DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right pleural effusion, right hemothorax DUE TO (c) Acute leukemia with hepatomegaly, splenomegaly			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. 19 p.m.		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from March 23, 19 62 to March 27, 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 27, 19 62 , and that death occurred at 8:20PM from the causes and on the date stated above.			
22a. SIGNATURE J. David Heywood M.D.		22b. DATE SIGNED 3/28/62	
22c. PHYSICIAN'S NAME (Type) J. David Heywood, M.D.		22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial 3/28/62		23b. DATE THEREOF 3/28/62	
23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		23d. LOCATION (City, town or county) (State) Peoria, Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR Charles S. Kraus	
25b. REGISTRAR'S SIGNATURE		25c. DATE MAR 30 '62	

03514

03501

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

Illinois

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03522						03515					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)					
a. COUNTY Montgomery MARYLAND						b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 24					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 623-Gist Ave.						d. STREET ADDRESS 623 Gist Avenue					
a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
Lottie			Lucetta			Schorr			March 8 19 62		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18 1886		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days	
										IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Virginia		
13. FATHER'S NAME John William Whitmere						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
14. MOTHER'S MAIDEN NAME Lydia Anne Olinger											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) -- --				16. SOCIAL SECURITY NO. None		17. INFORMANT John W. Schorr Address 7305-Willow Ave T.P.Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardiovascular Disease 6-8 yrs. DUE TO (e), stating the underlying cause last. (c)											
INTERVAL BETWEEN ONSET AND DEATH Immediate											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3/8 1962 to 3/8 1962 , That (I) (we) last saw the deceased alive on 3/8 1962 , and that death occurred at 10 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Charles E. Woodson M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3/8/62		
22c. PHYSICIAN'S NAME (Type) CHARLES E. WOODSON						22d. ADDRESS 1801 Eye St. N.W. Wash. 6, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/12/62			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City, town or county) (State) Prince Georges County, Md.		
24 FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.						ADDRESS 2901 14th St., N.W. Washington 9, D.C.			25a. REC'D BY REGISTRAR MAR 12 '62		
									25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

M

Montgomery

Silver Spring

655-61st Ave.

Boatie

Female

Rowanville

John William Whitman

Home

6000 W. Schott

John Anne Gilmore

Virginia

June 18-1933

Robert

623 61st Avenue

Silver Spring

Montgomery

65562

03513

Serial 3423/82

Court Hill Mining Co.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Page 4 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND									
03523 Item 23b, Film G309 3/16/62 1wk									
03516									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY in 1b 40 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE North Carolina b. COUNTY Lowell c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 95 d. STREET ADDRESS 70 X 3				
3. NAME OF DECEASED (Type or print) Donna Lynn Scott					4. DATE OF DEATH Month March , Day 12 , Year 1962				
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 21, 1962		9. AGE (In years last birthday) yrs. 1 Months 20 Days 1 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gus E. Scott					14. MOTHER'S MAIDEN NAME Edna Ann Falls				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTHROGRYPOSIS MULTIPLEX CONGENITA 758-6 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 1, 1962 , to March 12, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 12, 1962 and that death occurred at 10:40 AM the causes and on the date stated above.									
22a. SIGNATURE Bernard H. Feldman M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED March 13, 1962		
22c. PHYSICIAN'S NAME (Type) BERNARD H. FELDMAN LT MC USN					22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF March 15, 1962		23c. NAME OF CEMETERY OR CREMATORY Gaston Memorial			23d. LOCATION (City, town or county) (State) Gastonia, North Carolina		
24. FUNERAL HOME SIGNATURE Rinaldi Funeral Home ADDRESS 7400 Georgia Ave., WDC					25a. REC'D BY REGISTRAR MAR 14 '62		25b. REGISTRAR'S SIGNATURE Charles S. Kraus		

2170

(M)

65525

18510

Referred (Amel)

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

1
M
90
I

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03524					03517				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Montgomery MARYLAND					a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Kensington				Westhaven 56					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
Carroll Hall Sanitarium					5110 Brookview Drive				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Charles Middle Edward Last Sebastian, Jr.					Month March Day 3 Year 19 62				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
male		white				9/12/1880		81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret. Bureau Engraving U. S. Gov't						Washington, D. C.		U. S. A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Edward Sebastian					Roberta Dyer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.				
no					none				
17. INFORMANT					Address 5110 Brookview Drive Westhaven, Md.				
Charles E. Sebastian, Jr.									
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								1 hr.	
4-20-1 DUE TO Acute Myocardial Infarction									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis									
(c) Generalized Arterio-Sclerosis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						(State)
21. I certify that (I) (this hospital) attended the deceased from 1/12/1962 to 3/3/1962 that (I) (was) last saw the deceased alive on 3/2/1962 and that death occurred at 9:00 A.M. from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
E. Stuart Lyddane					3/3/62				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
E. Stuart Lyddane, M.D.					3066 - Queen St. N. W.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		
Burial			3/6/62		Oak Hill Cemetery		Washington, D. C.		
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
The S. H. Hines Co. Washington, D. C.					5 '62		Charles E. Hines		

(M)

03517

03524

Remington
Sears
Edwards
Sebastian
White
Washington
D.C.

The S. H. Bines Co. Washington, D.C.
For Mail Company
Washington, D.C.

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03525
CERTIFICATE OF DEATH
03518

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE North Carolina b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Concord	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital		d. STREET ADDRESS 254 N. Church St.	
3. NAME OF DECEASED (Type or print) First Middle Last Marvin Walter SECHLER		4. DATE OF DEATH Month Day Year March 1 1962	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 November 1939
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marshall Sechler		14. MOTHER'S MAIDEN NAME Hedgie Wray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother: Hedgie Sechler		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rhabdomyosarcoma, retroperitoneal 1977-9 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 18 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 17 November 1961 to 1 March 1962, that (X) (we) last saw the deceased alive on 1 March 1962, and that death occurred at 4:15 PM on the causes and on the date stated above.			
22a. SIGNATURE A.T. Thorp		22b. DATE SIGNED 2 March 1962	
22c. PHYSICIAN'S NAME (Type) A.T. THORP, LDR MC USN		22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/62	
23c. NAME OF CEMETERY OR CREMATORY Carolina Memorial		23d. LOCATION (City, town or county) (State) Concord, North Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		25a. REC'D BY REGISTRAR MAR 5 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

(M)

08550

CERTIFICATE OF DEATH

08518

LOCAL CERTIFICATE

STATEMENT

CONCORD

STATEMENT (Continued)

CONCORD, NORTH CAROLINA

STATEMENT (Continued)

November 1950

STATEMENT (Continued)

North Carolina

U.S.

North Carolina

STATEMENT (Continued)

CONCORD, NORTH CAROLINA

Y.

4:15 PM

STATEMENT

CONCORD, NORTH CAROLINA

U.S. DEPT. OF HEALTH

U.S. DEPT. OF HEALTH

CONCORD, NORTH CAROLINA

CONCORD, NORTH CAROLINA

STATEMENT

CONCORD, NORTH CAROLINA

TO BE FILED IN THE DEATH CERTIFICATE BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be examined by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03526
03519
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>107 Dawson Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>107 Dawson Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROBERT GRANT SHAW</u> First Middle Last		4. DATE OF DEATH <u>March 10, 1962</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/39</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>579-48-4629</u>	17. INFORMANT <u>Marion S. Shaw-Item # 2</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 321X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, left hemiplegia.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>March 10, 1962</u> that (I) (we) last saw the deceased alive on <u>March 10, 1962</u> and that death occurred at <u>SLP</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. A. Linthicum, M.D.</u> M.D.		22b. DATE SIGNED <u>3/10/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. A. Linthicum</u>		22d. ADDRESS <u>1105 Washington St., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>3/13/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>	23d. LOCATION (City, town or county) (State) <u>Prince George Co., Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave.</u> <u>Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 13 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

03219

35480



RECEIVED
JAN 10 1961
U.S. AIR FORCE
HONOLULU, HAWAII

TO HOSPITAL, OR TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03527

CERTIFICATE OF DEATH

03520

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 34	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2600 Terrapin Rd.		d. STREET ADDRESS 2600 Terrapin Rd.	
3. NAME OF DECEASED (Type or print) First EVA Middle LEONA Last SHERMAN		4. DATE OF DEATH Month March Day 24 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1886
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Month 2 Day 4 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Ryder	
14. MOTHER'S MAIDEN NAME Juliet Sprague		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 477-16-4883D		17. INFORMANT Mrs. Charles Preston, 2600 Terrapin Rd. S.S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis 722.0 DUE TO (b) Severe Rheumatoid Arthritis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. treated with Cortisone DUE TO (c) 3 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1 1959 to March 24 1962 that (I) (we) last saw the deceased alive on Mar 24 1962 and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John J. Curry		22b. DATE 3/24/62	
22c. PHYSICIAN'S NAME (Type) JOHN J. CURRY		22d. ADDRESS 10620 Georgia Ave Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/28/62	
23c. NAME OF CEMETERY OR CREMATORY CRYSTAL LAKE CEMETERY		23d. LOCATION (City, town, or county) (State) MINNEAPOLIS MINNESOTA	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY INC		25a. REC'D BY REGISTRAR MAR 27 62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thibault		25c. REGISTRAR'S SIGNATURE	



DEATH CERTIFICATE

1932

1932

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Date of death
7. Place of death
8. Cause of death
9. Signature of physician
10. Signature of registrar

11. Name of informant
12. Address of informant
13. Signature of informant
14. Date of completion
15. Registrar's office
16. County
17. State

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

75

I

0

1

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1 MARYLAND

03528

CERTIFICATE OF DEATH

03521

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium and Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt, d. STREET ADDRESS 2 Empire Place, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Shoemaker		4. DATE OF DEATH March 6, Month 19 62 Day 10 Year		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1962		9. AGE (in years last birthday) yrs. 6 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Thomas Edison Shoemaker				14. MOTHER'S MAIDEN NAME Betty Joyce Matney				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. no				17. INFORMANT father Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 761.0 DUE TO ASPHYXIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. TIGHT LOOP CORD AROUND NECK DUE TO (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 10 MIN 10 MIN									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M, from the causes and on the date stated above.																					
22a. SIGNATURE Robert A. Hare M.D.												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 3/6/62					
22c. PHYSICIAN'S NAME (Type) Robert A. Hare												22d. ADDRESS 1352 Unity Blvd E.I.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 3-6-62				23c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium and Hospital, Takoma Park, Md.													
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington San. & Hospital												25a. REC'D BY REGISTRAR MAR 8 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Hare					

2-006303

13521

13522



13521 13522

13521 13522

13521 13522

13521 13522

13521 13522

13521 13522

13521 13522

13521 13522

13521 13522

13521 13522

13521 13522

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 of 4. The law requires that the death certificate be executed 24 hours after death. Page 4 of 4. The law requires that the death certificate be executed 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03529 CERTIFICATE OF DEATH 03522

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Falls Church d. STREET ADDRESS 1224 West Greenstead Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle Mae Last Shupe		4. DATE OF DEATH Month March Day 17 Year 19 62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 22, 1926	
9. AGE (In years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months 3 Days 17	
11. IF UNDER 24 HRS. Hours 1 Min. 1/2		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lester Craig		14. MOTHER'S MAIDEN NAME Pearl Craig	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No		16. SOCIAL SECURITY NO. 228-28-4986	
17. INFORMANT The Medical Record		18. ADDRESS The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 593 X (b) Auricular flutter (c) Renal failure		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. 13 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Primary hyperparathyroidism		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 2 19 62 to March 17 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 17 19 62 , and that death occurred at 10:40 PM from the causes and on the date stated above.		22a. SIGNATURE Albert Ayerst Carr M.D. 22b. DATE SIGNED 3/18/62	
22c. PHYSICIAN'S NAME (Type) Albert Ayerst Carr, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/20/62	
23c. NAME OF CEMETERY OR CREMATORY Spoon Creek Cemetery		23d. LOCATION (City, town or county) (State) Critz, Patrick Co. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. P... Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE MAR 20 '62	
25b. REGISTRAR'S SIGNATURE Arthur E. H...			

(M)

3352

03552

History
15 days
The Clinical Center, Bethesda, Md.
1921 West Maryland Street
March 17 62
xx
October 22, 1962
white
Female
Housewife
None
Virginia
U.S.A.
Pearl Creek
The Medical Record
The Clinical Center, Bethesda, Md.
62-28-1962
Cardiac arrest
Anular lesion
Renal failure
Primary hyperparathyroidism
xx
March 17 62
March 2 62
March 17 62
xx
3/28/62
The Clinical Center, Bethesda, Md.
Institute of Health, Bethesda, Md.

Albert J. Cantor

Albert J. Cantor, M.D.

Albert J. Cantor, M.D.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

75

1

0

2

03530 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** **03523**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San. & Hosp.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>23 Silver Spring</u> d. STREET ADDRESS <u>175 E. Wayne Ave.</u>														
3. NAME OF DECEASED (Type or print) <u>Fanny (nmn) Siegel</u>					4. DATE OF DEATH Last Month Day Year <u>3 2 1962</u>														
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 10 - 1891</u>		9. AGE (In years last birthday) <u>70</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Months	Days	Hours	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>					11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Samuel Friedman</u>					14. MOTHER'S MAIDEN NAME <u>Annie Glass</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>NONE</u>					17. INFORMANT <u>Mrs. Sally Goldstein</u> Address <u>(same as 2d. above)</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u> sudden </u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED				
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEIT</u>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					Address (Street, city, town, or county) <u>Mar 2 1962</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>3/4/1962</u>					22c. NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u>					22d. LOCATION (City, town, or country) (State) <u>FALLS CHURCH, VA.</u>				
23. FUNERAL DIRECTOR <u>Deedee Jewel Anne 4217-9th St</u>										24a. REC'D BY REGISTRAR <u>5 '62</u>					24b. REGISTRAR'S SIGNATURE <u>Robert L. Kline</u>				

08258

08258

M

the 21st of May 1941
the 21st of May 1941

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03531

03524

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland f. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 6005 Landon Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hope Middle Dalberta Last Slone		4. DATE OF DEATH Month March Day 14 Year 19 62	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1905 9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR: Months 2 Days 25 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Ohio 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME W. J. Hewitt		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Horace E. Slone-Husband-same 2d		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Dehydration + starvation from P. flexu obot. DUE TO (c) Carcinoma of Pancreas - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		INTERVAL BETWEEN ONSET AND DEATH 4 days 2 weeks 8 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11 July 1961 to 14 March 1962 , that (I) (we) last saw the deceased alive on 13 March 1962 , and that death occurred at 12:55 A M, from the causes and on the date stated above.			
22a. SIGNATURE John G. Ball		22b. DATE SIGNED 3/14/62	
22c. PHYSICIAN'S NAME (Type) John G. Ball		22d. ADDRESS Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 3/17/62	
23c. NAME OF CEMETERY OR CREMATORY Sandyville Cemetery		23d. LOCATION (City, town or county) (State) Sandyville, Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

(M)

03731

03524

ontology

Maryland

Montgomery

bedstead

bedstead

Stourton Hospital

6007 London Lane

hope

Delaware

stone

patch

14

03

female white

Dec. 10, 1905

3

25

housewife

Ohio

USA

W. J. Hewitt

Unknown

Unknown - Horace E. Stone - husband - see 24

bedstead, Maryland

John G. Hall

Emory - transfer 2/1/02 Sandusville Cemetery - Sandusville, Ohio

Robert A. Humphrey, bedstead, Maryland

1
FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03532

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03525

Item 9 Film G309 3/21/62 iwk

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 14 Silver Spring			
3. NAME OF DECEASED (Type or print) First Everett Middle L. Last Smith				d. STREET ADDRESS Box 76 Colesville/			
5. SEX Male				6. COLOR OR RACE Col.			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9/2/28			
9. AGE (In years last birthday) 33 3/4 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work				11b. KIND OF BUSINESS OR INDUSTRY			
12. BIRTHPLACE (State or foreign country) Maryland				13. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. FATHER'S NAME Walter Smith				15. MOTHER'S MAIDEN NAME Evelyn Warner			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				17. SOCIAL SECURITY NO. Walter Smith, father			
18. INFORMANT same as above				Address			
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral + pulmonary edema DUE TO (b) Smoke inhalation DUE TO (c) 3rd degree burns - Chest + upper extrem. Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Acute pancreatitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Bed + clothing caught afire while smoking							
INTERVAL BETWEEN ONSET AND DEATH 3 days							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home							
20c. TIME OF INJURY Month, Day, Year 7:45 p.m. 3-11 1962							
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>							
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.) Home							
20f. (City or town) (County) (State) Silver Spring, Mont. Md.							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
DATE SIGNED 3-15-62							
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 3/17/62							
22c. NAME OF CEMETERY OR CREMATORY Good Hope.,							
22d. LOCATION (City, town, or country) (State) Colesville, Md.							
23. FUNERAL DIRECTOR Robert L. Snowden.							
ADDRESS Rockville, Md.							
24a. REC'D BY REGISTRAR MAR 19 '62							
24b. REGISTRAR'S SIGNATURE Arthur L. Krasner							

MEDICAL CERTIFICATION

03222

03222



TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

74

I

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03533					03526									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY <i>Montgomery</i> MARYLAND					e. STATE <i>md.</i> b. COUNTY <i>Mont. Co.</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>54 Chevy Chase</i>									
c. LENGTH OF STAY IN 1b <i>3 days</i>					d. STREET ADDRESS <i>4136 - Le Land St.</i>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First <i>Irene</i> Middle <i>B.</i> Last <i>Smith</i>					Month <i>3</i> Day <i>19</i> Year <i>1962</i>									
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/26/85</i>		9. AGE (In years last birthday) <i>77</i> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>practical nurse private</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME <i>William T. Burdine</i>					14. MOTHER'S MAIDEN NAME <i>Julie Fauce Wagner</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <i>301-10-9845</i>					17. INFORMANT <i>Adelia J. Downey</i> Address <i>58 Ave. Above.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH <i>46 hours</i>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Perforation Small Bowel</i>										46 hours				
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <i>Strangulated Hernia in Obturator Foramen</i>										5 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.										20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <i>3-14</i> , 19 <i>62</i> to <i>3-19</i> , 19 <i>62</i> that (I) (we) last saw the deceased alive on <i>3-19</i> , 19 <i>62</i> and that death occurred at <i>2:30 PM.</i> from the causes and on the date stated above.										22a. SIGNATURE <i>P.P. Andrews</i> M.D.				
22b. DATE SIGNED <i>3-19-62</i>										22c. PHYSICIAN'S NAME (Type) <i>P. P. Andrews</i>				
22d. ADDRESS <i>4201 Fessenden St. N. W., Wash DC</i>										22e. REC'D BY REGISTRAR <i>Mar 22 62</i>				
22f. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>										22g. DATE				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>										23b. DATE THEREOF <i>3/22/62</i>				
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Cemetery</i>										23d. LOCATION (City, town or county) (State) <i>Arlington, Virginia</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey, Bethesda, Maryland</i>										24. ADDRESS				

03533

03533

(M)

Robert A. Pugh, Bethesda, Maryland

Acting on Secretary

General

Andrew

4501

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

1942

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03534

03527

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY Washington D.C.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington D.C. 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Waverley Sanitarium				d. STREET ADDRESS 2301 Conn Ave NW			
3. NAME OF DECEASED (Type or print) Mildred Duvall Smoot				4. DATE OF DEATH March 16 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/6/1896	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Montg. Cty, School Teacher				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Nelson H askell Duvall				14. MOTHER'S MAIDEN NAME Georganne Williams			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 219-36-7655			
17. INFORMANT Richard Kudlich, Kensington, Md.				Address Nephew			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertension. (a), stating the underlying cause last. } DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 16, 1957 to March 16, 1962 that (I) was last saw the deceased alive on March 15, 1962 , and that death occurred at 12:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE C. J. Everding, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/16/62	
22c. PHYSICIAN'S NAME (Type) C. J. Everding				22d. ADDRESS 4401 East-West Highway, Beth. Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/16/62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				25a. REC'D BY REGISTRAR MAR 19 '62		25b. REGISTRAR'S SIGNATURE Charles E. Kline	

03257

03257



Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

Handwritten text, possibly a name or title.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03535
03528
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>2215 Kimball Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Laid</u> Middle <u>Wingate</u> Last <u>Snell</u>				4. DATE OF DEATH <u>March 24 1962</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 30 1870</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clergyman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Minne</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Snell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Faye</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Wingate Snell</u>				Address <u>2215 Kimball Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4200 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1957</u> to <u>March 24 1962</u> , that (I) (we) last saw the deceased alive on <u>3-29 1962</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>C. H. Ligon</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. Ligon</u>				22d. ADDRESS <u>Sandy Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT-BURIAL</u>		23b. DATE THEREOF <u>3/25/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FAIRHOPE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>FAIRHOPE, BALDWIN CO., ALABAMA</u>	
24. FUNERAL HOME, ADDRESS <u>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>Mar 30 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>	

8530

2520

1

1993-1994

9705

3/9/62

William L. Plummer

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03530

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>8100 Hammond Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium - Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY J. SOUDER</u>		4. DATE OF DEATH <u>March 27 1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-92</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt. - Retired Photo Engraver - Army Map Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph A. Souder</u>		14. MOTHER'S MAIDEN NAME <u>Dora Charlotte Reckeweg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give year or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Wash San - Hosp Chart</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Old ant myocardial infarction</u> (c) <u>Arturoschotic process</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>none?</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/18/1962</u> to <u>3/27/1962</u> that (I) (we) last saw the deceased alive on <u>3/26/1962</u> and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas H Volonty</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas H Volonty</u>		22d. ADDRESS <u>7401 Blair Road, N.W. Wash.D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/30/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. - Arlington, Virginia</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>S.A. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>2901 14th St NW</u> DATE <u>MAR 29 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

03530

03530

TECHNICAL

DELIVERED

ON THE 28th

1961 11th Nov, 11.11.61

1961 11th Nov, 11.11.61

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03538 CERTIFICATE OF DEATH 03531

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 12</u> c. LENGTH OF STAY IN 1b <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Takoma P. Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u> d. STREET ADDRESS <u>717 Erie Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Junius Early Sowers</u>		4. DATE OF DEATH <u>March 14 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-86</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer - Boiler Room</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer - College</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>American</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>John W Sowers</u>		14. MOTHER'S MAIDEN NAME <u>Demorris Dickerson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Chart</u>	
17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subphrenic abscess</u> 54000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Leak thru stomach wall</u> DUE TO (c) <u>Partial resection of stomach for ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congestive heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 20 1962</u> to <u>Mar 14 1962</u> , that (I) (we) last saw the deceased alive on <u>March 14 1962</u> , and that death occurred <u>6:30 p.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W W Eastman</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>W. W. EASTMAN</u>		22d. ADDRESS <u>8700 Colverville Rd, Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE THEREOF <u>March 16 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Adelphi Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Mar 19 62</u>	
ADDRESS <u>254 Carroll St, NW, Wash. DC</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

03231

EXHIBIT OF DATA

03230

M

Y

Feb 20 1961

10

W. N. EASTMAN

W. N. EASTMAN

10/10/61

10/10/61

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

74

I

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03539					03532				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)				
a. COUNTY		Montgomery			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda			b. COUNTY		Montgomery		
c. LENGTH OF STAY IN 1b		9 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		26 Silver Spring		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Suburban Hospital			d. STREET ADDRESS		2300 Colston Drive—Apt. 102		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. SEX		
First Middle Last					Month Day Year		Female		
Madge S. (Shaw) Sponseller					March 3, 1962				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White				9/18/78		83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own Home		Maryland		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Frank T. Shaw				Myra Cull					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
No. None				None		Donald Sponseller 36 Count St. Westminister, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage									
DUE TO (b) Arteriosclerotic Heart Disease									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ?									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 1957, to 3/3, 1962, that (I) (we) last saw the deceased alive on March 2, 1962, and that death occurred at 5:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
J. Marion Bankhead M.D.							3/3/62		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
J. Marion Bankhead					9241 Col. Blvd. Silver Spring Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		3-5-62		Westminster Cemetery		Westminster Carroll Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Raymond A. Jones					434 Georgia Ave		Arthur S. Thomas		
Warner E. Pumphrey, Inc. Silver Spring, Maryland					DATE MAR 7 '62				

M

03233

03233

Johnson Hospital

Johnson Hospital

Admission

Admission

Private - White

Private - White

X

13

Hospital

Hospital

Franklin, New

Franklin, New

Room

Room

Room

Continued from page 2
Continued from page 2

Page 2 of 2

J. Marion Burkhead

2141 Col Blvd
Spring MA

2-2-70

George S. Humphrey, Inc. Silver Spring, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03540 CERTIFICATE OF DEATH 03533

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 4212B Knox Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alford Palmer Stark		4. DATE OF DEATH Month March , Day 26 , Year 1962	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1884
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer	11. BIRTHPLACE (County & State, or foreign country) Texas
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jeremiah M. Stark	
14. MOTHER'S MAIDEN NAME Serena V. Mattox		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I & WW II	
16. SOCIAL SECURITY NO. WW I & WW II		17. INFORMANT Wife: Mrs. Mae E. Stark, Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of pancreas with widespread metastasis DUE TO (b) Terminal intestinal hemorrhage CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 19, 1962 , to March 26, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 26, 1962 , and that death occurred at 6:25 AM on the causes and on the date stated above.			
22a. SIGNATURE D. L. Kettering LT MC USN		22b. DATE SIGNED March 26, 1962	
22c. PHYSICIAN'S NAME (Type) D. L. KETTERING LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-28-62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE GASCH FUNERAL HOME, HYATTSVILLE, MARYLAND		25a. REC'D BY REGISTRAR MAR 28 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

03250

03250



Mr. [illegible]

Mr. [illegible]

College Park

Y. [illegible]

(Initial)

Health Room [illegible]

U. S. Naval Hospital

Alton [illegible]

September 2, 1944

Crucifixion

USA

USA

Naval Officer

James V. [illegible]

James M. [illegible]

Wife: Mrs. [illegible]

Wife: [illegible]

Memorandum of [illegible]

Personal [illegible]

March 20, 1944

March 19, 1944

1

March 20, 1944

March 20, 1944

X [illegible]

D. E. [illegible]

U. S. Naval Hospital, [illegible]

Washington, D. C.

Washington, D. C.

5-28-44

Initial

U. S. Naval Hospital, [illegible]

tem 18 File 309 5-25 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03541 CERTIFICATE OF DEATH 03534

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Louisiana b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN Is 23 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bossier City		56X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 433 Riverdale Drive		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Shirley Ann Stevens				4. DATE OF DEATH March 16, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 January 1957	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joel B. Stevens				14. MOTHER'S MAIDEN NAME Roberta Summers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record, The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Probable Septicemia</u> (c) <u>Acute Lymphocytic Leukemia with Hepato splenomegaly</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 Weeks 1 Year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from Feb. 21, 1962, to March 16, 1962, that (I) (we) last saw the deceased alive on March 16, 1962, and that death occurred at 3:07 PM from the causes and on the date stated above.							
22a. SIGNATURE J. David Heywood				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 3-16-62		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. David Heywood M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/20/62		23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY		23d. LOCATION (City, town or county) (State) BOSSIER PARISH LOUISIANA	
24 FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS 1400 Chapin St. N.W. WASH. D.C.		25a. REC'D BY REGISTRAR MAR 20 '62	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1
M
50
1
2
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



re: [illegible]

Location: [illegible]

The Clinic [illegible]

the [illegible]

with [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

the [illegible]

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03542

03535

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u> d. STREET ADDRESS <u>6702 West Park Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie (NMN) Stiefel</u>		4. DATE OF DEATH Month Day Year <u>March 13 1962</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-5-89</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>							
13. FATHER'S NAME <u>Adolph Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Julia Eckstein</u>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>091-14-2349</u>				17. INFORMANT Address <u>Park West Memorial Chapel - New York</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive cardio-vascular disease</u> (a), stating the underlying cause last. DUE TO (c) <u>unknown</u>																INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>2-23</u> , 19 <u>62</u> to <u>3-13</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3-13</u> , 19 <u>62</u> , and that death occurred at <u>1:05</u> P.M., from the causes and on the date stated above.																		22b. DATE SIGNED <u>3-13-62</u>	
22a. SIGNATURE <u>Eino Magi</u>						22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>98th St. Blvd. E. Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>3/14/62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Reverside Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Rockville Park, New Jersey</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund Broshe</u>										25a. REC'D BY REGISTRAR DATE <u>MAR 15 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

0355

STATE OF TEXAS

1913

M

Attest my hand and seal of office this 1st day of March 1913.

Notary Public for the State of Texas

My commission expires the 1st day of March 1914.

Witness my hand and seal of office this 1st day of March 1913.

Notary Public for the State of Texas

My commission expires the 1st day of March 1914.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03543

03536

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>34 Wheaton</u>	
c. LENGTH OF STAY in 1b <u>4 days</u>		d. STREET ADDRESS <u>3812 Greenly Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Hugh</u> Last <u>Strohmeyer</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 22, 1961</u>
9. AGE (In years last birthday) yrs. <u>2</u> Months <u>21</u> Days <u>21</u>		10. IF UNDER 1 YEAR Hours <u>21</u> Min. <u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? -----	
13. FATHER'S NAME <u>John H. Strohmeyer</u>		14. MOTHER'S MAIDEN NAME <u>Joyce Aileen Parr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <u>Hospital Records</u>		Address -----	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tricuspid Atresia (Post operative)</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 12</u>, 19 <u>62</u> to <u>March 15</u>, 19 <u>62</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 15</u>, 19 <u>62</u> , and that death occurred at <u>4:21 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. L. Beeby</u>		22b. DATE SIGNED -----	
22c. PHYSICIAN'S NAME (Type) <u>J. L. BEEBY LT MC USN</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-19-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR <u>MAR 19 '62</u>	
ADDRESS <u>Funeral Home, 7557 Wisc. Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1-031421

08-30

08-30

M

John E. ...
The ...
...

...

...

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03537

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

74

I

2

2

1. PLACE OF DEATH a. COUNTY Bethesda Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hazel V. Styers				4. DATE OF DEATH March 3, 1962			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1912	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 4 Days 3		IF UNDER 24 HRS. Hours 19 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY XXXXXX		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Nine				14. MOTHER'S MAIDEN NAME Claudie Baxley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Paul same as above - Husband	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema DUE TO Cerebral hemorrhage DUE TO Ruptured aneurysm - at mid-cerebral artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 330X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Was pushing auto at home when she became ill & collapsed							
INTERVAL BETWEEN ONSET AND DEATH 19 hrs							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED Mar 3 1962			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/62		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland				24. REC'D BY REGISTRAR WAR 7 '62			
				25. REGISTRAR'S SIGNATURE Arthur S. Kraus			

03537



WYOMING, NEWLAND

CLINTON PARK

WYOMING, NEWLAND

Robert A. Humphrey, Engineer, Wyoming

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03545
CERTIFICATE OF DEATH
03538

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 17 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE M.D. (D.C.) b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 5510 Ridgefield Rd. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM S. SUMMERS First Middle Last 4. DATE OF DEATH March 10 19 62		5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8/30/84 9. AGE (In years last birthday) 77 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) VIRGINIA 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM SUMMERS 14. MOTHER'S MAIDEN NAME SARAH Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 577 03 8558 17. INFORMANT daughter, Mrs. Olive O'Connor Address Same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebrovascular accident DUE TO (b) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 days 2 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (his hospital) attended the deceased from Jan 2, 1962 to March 10, 1962, that (I) (we) last saw the deceased alive on March 10, 1962, and that death occurred at 10 A.M. from the causes and on the date stated above.	
22a. SIGNATURE Dr. Joseph P. Kenrick 22c. PHYSICIAN'S NAME (Type) Dr. Joseph P. Kenrick 22d. ADDRESS 6450 Wainman Ave, Bethesda, Md.		22b. DATE SIGNED 3/10/62 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-13-1962 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill 23d. LOCATION (City, town or county) (State) Suitland, Md.		24. FUNERAL DIRECTOR'S SIGNATURE R. A. Mattingly ADDRESS 131-11th St. S.E. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE MAR 12 '62	

86287

2020

Interventions

[illegible]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03546

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03539

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>130 Phosda.</u> D.O.A.			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>37 Wheaton</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u> <u>Westmore Ave & Cedar Lane</u>			d. STREET ADDRESS <u>13110 Henderson Ave.</u>		
3. NAME OF DECEASED (Type or print) <u>Joyce Ellen Sweeney</u>			4. DATE OF DEATH <u>3/19/62</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/29</u>	9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Cafeteria Asst.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Radnor Elementary School</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Raymond Hough</u>		
14. MOTHER'S MAIDEN NAME <u>Louise Legge</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>229-26-9888</u>			17. INFORMANT <u>Bernard Sweeney - Item 2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of Cord</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Fracture & dislocation C5-</u> (c) <u>Auto accident</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was driven of car on which a truck upset</u>		
20c. TIME OF INJURY Hour <u>2:25</u> p.m. Month, Day, Year <u>3-19 1962</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Bethesda</u> (County) <u>Montg</u> (State) <u>md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-20-62</u>		
			Address (Street, city, town, or county)		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-23-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>		
23. FUNERAL DIRECTOR <u>Raymond A. Jiska</u> ADDRESS <u>8434 Georgia Ave</u>			24a. REC'D BY REGISTRAR <u>MAR 22 '62</u>		
S Warner E. Pumphrey, Inc. Silver Spring, Md.			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>		

00248

M

CERTIFICATE OF DEATH

03547

03540

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 2 weeks		d. STREET ADDRESS 6009 Rossmore Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Hall Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ESTELLE Last SWOPE		4. DATE OF DEATH Month March Day 18 , Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 4 Days 15	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (County & State, or foreign country) Alexandria, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Manley T. Rust	
14. MOTHER'S MAIDEN NAME Mary Estelle Nevett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter Address Mrs. Dorothy Zimowski	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) GENERALIZED ARTERIOSCLEROSIS (c) ADVANCING YEARS (OLD AGE)			INTERVAL BETWEEN ONSET AND DEATH 1 WK 10 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JAN 15, 1962 to 3/18, 1962 that (I) (we) last saw the deceased alive on 3/16, 1962 and that death occurred at 4:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature] M.D.		22b. DATE SIGNED 3/19/62	
22c. PHYSICIAN'S NAME (Type) GO I DONOVAN M.D.		22d. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/21/62	23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	23d. LOCATION (City, town or county) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 22 '62 DATE 25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1934

03340

MINISTRY OF HEALTH

MINISTRY OF HEALTH

MINISTRY OF HEALTH

2 weeks

2 weeks

Carroll Hall, Washington

0000 Washington, D.C.

2000

ESTABLISHED

1934

Vol. 2, 1934

Female, White

Washington, D.C.

Washington, D.C.

New York, N.Y.

Charles T. Roper

New York, N.Y.

1934

1934

1934

Robert A. Tamm, U.S. Supreme Court

Washington, D.C.

TO HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. Pages 4 and 5 are to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03548
CERTIFICATE OF DEATH
03541

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>25 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Rockville</u> d. STREET ADDRESS <u>11901 Rockville Pike Lot J</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Charles T. Tavenner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1962</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/19/19</u>		9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mover</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Moving</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Charles Welby Tavenner</u>						14. MOTHER'S MAIDEN NAME <u>Mary Ellen MacDonough</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>223-22-7786</u>		17. INFORMANT Address <u> </u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>466X</u> IMMEDIATE CAUSE (a) <u>PULMONARY Embolus</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Thrombosis, peripheral veins</u> (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>1-2h</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1962</u> to <u>March 26, 1962</u> that (I) (we) last saw the deceased alive on <u>March 26, 1962</u> and that death occurred at <u>11:25 AM</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>John E. Everett</u>						22b. DATE SIGNED <u>3/26/62</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN E EVERETT</u>									
22d. ADDRESS <u>9400 Conn Av. Kensington Md</u>						22e. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>						22f. REGISTRAR'S SIGNATURE					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/29/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>				23d. LOCATION (City, town or county) (State) <u>Falls Church Virginia</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lyon Wheeler</u>						24b. ADDRESS <u>1331 East Montgomery Ave Rockville Maryland</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>									

03211

3248

1

1

Handwritten notes at the bottom of the page, including the word "SECRET" and other illegible text.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

3542
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03549
CERTIFICATE OF DEATH
03542

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE District Of Columbia D. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 1719 Monroe Street, N.E.	
3. NAME OF DECEASED (Type or print) Mary Thomas Louise Thomas		4. DATE OF DEATH Month March Day 27 Year 19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 13, 1896
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 1 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Richards		14. MOTHER'S MAIDEN NAME Lucinda Page	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-30-3756	
17. INFORMANT The Medical Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive electrolyte imbalance DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Macroglobulinemia with bone and renal disease DUE TO (c) 8 months	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
2Dc. TIME OF INJURY Hour a.m. 19 p.m.	2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	2Df. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 25, 1961 to March 27, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 27, 1962 , and that death occurred at 8:25 PM from the causes and on the date stated above.			
22a. SIGNATURE Michael L. Lazor		22b. DATE SIGNED 3/28/62	
22c. PHYSICIAN'S NAME (Type) Michael L. Lazor, M.D.		22d. ADDRESS The Clinical Center, National Institutes Of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3.31.62	23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY	23d. LOCATION (City, town or county) (State) WASHINGTON, D.C.
24. FUNERAL DIRECTOR'S SIGNATURE Robert H. Lazor		25a. REC'D BY REGISTRAR APR 2 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Pious		25c. ADDRESS 1820 9TH ST, N.W.	
WASHINGTON, D.C.			

08343

08343

Director of Columbia

containing

Washington

Bellevue

1719 Prince Street, N.E.

The Clinical Center, Bethesda, Md.

March 27,

Thomas

London

My Dear

London

Left

x

Glancing

Seems to be

London, D. C.

217-30-122

10

... live a more ...

... in front of ...

W. H.

Sept. 22, 61 March 17, 62

March 27, 62

The Clinical Center, National
Institute of Health, Bethesda, Md.

Richard P. Lipp

London, D. C.

WOODLAWN CEMETERY WASHINGTON, D.C.

1850 21st St. N.W.

Richard P. Lipp

ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4, to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03550				CERTIFICATE OF DEATH				03543			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>30 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>						d. STREET ADDRESS <u>3133 Conn Ave. N.W.</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia A.9 Thompson</u>						4. DATE OF DEATH <u>March 13, 1962</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/29/79</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Maurice Adler</u>						14. MOTHER'S MAIDEN NAME <u>Gertrude Harper</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Raymond Thompson, son-in-law</u>				Address <u>119 Hesketh St. Ch. Ch., Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure - acute</u> DUE TO (b) <u>Coronary Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>1 mo</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10, 1962</u> to <u>March 13, 1962</u> that (I) (we) last saw the deceased alive on <u>3/13, 1962</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. Wm. F. Luckett</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Wm. F. Luckett</u>						22d. ADDRESS <u>5000 Reno Road, N.W. Washington, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-15-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Bendersome, Inc. 1756 Pa. Ave. N.W.</u>						25a. REC'D BY REGISTRAR <u>DATE MAR 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

03543

03750

M

Shawnee Hospital

Devine's House

Tr. Wm. E. Buckett

Oak Hill Cemetery

3-25-1982

2141

5000 Reno Road, N.W. Washington, D.C.

Washington, D.C. 20007

03551

CERTIFICATE OF DEATH

03544

Item 21 Film G311 4/16/62 mh

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 31 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 14 Ednor d. STREET ADDRESS 1 Millgrove Gardens e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) Joseph Franklin Tower		4. DATE OF DEATH Month March Day 31 Year 1962		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-26-23		9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months 3 Days 1		IF UNDER 24 HRS. Hours 24 Min. 15							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION REPR. NATIONAL PARK SERVICE				10b. KIND OF BUSINESS OR INDUSTRY National Park Serv				11. BIRTHPLACE (County & State, or foreign country) Michigan				12. CITIZEN OF WHAT COUNTRY? Amer.											
13. FATHER'S NAME FRANKLIN Tower				14. MOTHER'S MAIDEN NAME Florence Harder				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WW-II				16. SOCIAL SECURITY NO. 218-24-0844				17. INFORMANT Hospital Records Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO (b) SHOCK Post OPERATIVE DUE TO (c) COROTOMY Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 154X																INTERVAL BETWEEN ONSET AND DEATH 24 HRS 72 HRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ADENOCARCINOMA RECTUM WITH GEN. METASTASIS																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 62				20f. (City or town) (County) (State) 62			
21. I certify that (I) (this hospital) attended the deceased from MAR 1 , 19 62 , to MAR 31 , 19 62 ; that (I) (we) last saw the deceased alive on MAR 30 , 19 62 , and that death occurred at 4 A.M. from the causes and on the date stated above.																							
22a. SIGNATURE John P. Haberlin M.D. 22b. PHYSICIAN'S NAME (Type) John P. Haberlin								22c. ADDRESS 1015 Spring Street, Silver Spring, Maryland								22d. DATE SIGNED 3-31-62							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-3-62				23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery				23d. LOCATION (City, town or county) (State) Arlington, Virginia											
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Warner Address 8434 Georgia Ave. Silver Spring, Maryland								25a. REC'D BY REGISTRAR DATE APR 3 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Hanks											

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03514

03514

(M)

(1)

National Bank of Chicago

210-24-0000

10-11

2000 (10/1/1911) 10/1/1911
2000 (10/1/1911) 10/1/1911

10/1/1911

10/1/1911

10-11-11

10

1015 Spring Street, New York, N.Y.

John P. H. H. H.

10/1/1911

10/1/1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film G309 3/19/62 iwk

03552

03545

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in b. <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS <u>808 Aspen Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Carrie Ella Trivett</u>		4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1962</u>		5. AGE (In years last birthday) <u>88</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-1874</u>		9. AGE (In years last birthday) <u>88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>Barnabas Vrooman</u>			14. MOTHER'S MAIDEN NAME <u>Eleanor Smith</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Engell (sister) 808 Aspen St NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 4 43X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease many yrs.</u> (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 7</u> , 19 <u>58</u> to <u>12 March</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>12 March</u> , 19 <u>62</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Ernest E. Harmon</u>			22b. DATE SIGNED <u>12 March 62</u>		22c. PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon M.D.</u>
22d. ADDRESS <u>9301 Lakeside Rd. Silver Spring Md.</u>			22e. (State) <u>Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
23d. LOCATION (City, town or county) <u>Suitland</u>		23e. (State) <u>Md.</u>		23f. (County) <u>Harford</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dean Turner</u>			24a. REC'D BY REGISTRAR <u>15 MAR 1962</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

FOR STATE
HEALTH DEPT.

1

(M)

(I)

0

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
03553									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Montgomery</u> b. COUNTY <u>15X-1</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Heathensville - rural</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Found off River Rd. in woods</u>					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) <u>Baby Girl Unknown</u>					4. DATE OF DEATH Month <u>Mar</u> Day <u>18</u> Year <u>1962</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>W</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH				
9. AGE (In years last birthday) <u>7 mo</u>					10. IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u>				
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					12. BIRTHPLACE (State or foreign country)				
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknown - Estimated 7 mo fetus</u> 795.5 DUE TO <u>found in gallon jar - cord tied.</u> (b) <u>Had been dead for several weeks</u> DUE TO <u></u> (c) <u></u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DATE SIGNED <u>Mar 18 1962</u>									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
22b. DATE THEREOF <u>3/21/62</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>County Alms House Cemetery</u>									
22d. LOCATION (City, town, or country) (State) <u>Montgomery County, Maryland</u>									
23. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave.</u>									
ADDRESS <u>Rockville, Maryland</u>									
24a. REC'D BY REGISTRAR <u>Mar 22 '62</u>									
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>									

2-057626

08245

M

03517

(M)

(1)

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

M

94

I

0

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
03555					03548							
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)							
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		e. STATE		f. COUNTY			
Montgomery		Rockville			MARYLAND		Maryland		Montgomery			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Gilmore Rest Home					09 Rockville			804 Maple Avenue				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. IF UNDER 1 YEAR			6. IF UNDER 24 HRS.		
First Middle Last					Month Day Year		Months Days Hours Min.					
JENNIE L. VAN SICKLE					March 26, 19 62							
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		
Female		White				Sept. 7, 1890		71 yrs.		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife					Own Home		Pennsylvania		USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME							
Edward Kindred					Susanna Wenner							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address		
							F.A. VanSickle- Item # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X CEREBRAL THROMBOSIS										Six months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIAL HYPERTENSION										20 years		
(c) ARTERIO SCLEROSIS										20 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
D I A B E T E S M E L L I T U S												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
21c. TIME OF INJURY Month, Day, Year					21d. INJURY OCCURRED		21a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town)		(County) (State)	
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from Jan 2 1956 to Mar 26 1962, that (I) (we) last saw the deceased alive on Jan 23 1962, and that death occurred at 9:30 PM, from the causes and on the date stated above.												
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/26/62					
22c. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger, M.D.					22d. ADDRESS 310 W. Montg. Ave, Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county)			(State)	
Burial			3/28/62		Union			Burtonsville, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.							DATE MAR 27 '62		Curtis S. Frank			

VR A15 (4)
15M 9/60

05013

05013

M



TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03556

03549

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in lb <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sen. + Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>M. VIRGINIA</u> b. COUNTY <u>WARREN</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> BROWNTOWN d. STREET ADDRESS <u>4610 College Ave</u> 83X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>MARIA</u> Last <u>Marie Van Valey</u> 4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1962</u>				5. SEX <u>Fe</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-12-95</u> 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House mother</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Univ. of Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Collegeville, Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Edwin J. LaRose</u> 14. MOTHER'S MAIDEN NAME <u>Susan Sarah Hunsicker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u> 16. SOCIAL SECURITY NO. <u>095-30-6200</u> 17. INFORMANT <u>Hospital Records</u> Address <u> </u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> <u>420</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary atherosclerosis</u> (c) <u> </u> DUE TO cause last. <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>Several years</u>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Bile Peritonitis, Loculated</u> <u>2. Diabetes mellitus</u> <u>3. Cholelithiasis</u> <u>4. Chronic nephron nephrosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u>Collegeville</u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>October 1960</u> to <u>March 8, 1962</u> that (I) (we) last saw the deceased alive on <u>March 7, 1962</u> and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above.				22a. SIGNATURE <u>Russell B. Arnold</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>March 9, 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u> 22d. ADDRESS <u>8801 Collegeville Road</u> <u>Silver Spring, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>3-11-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Reformed Church of Collegeville, Pa Cemetery</u> 23d. LOCATION (City, town or county) <u>Collegeville</u> (State) <u>Pennsylvania</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Warner</u> 25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u> 25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey</u>				25c. ADDRESS <u>34 Georgia Ave</u> 25d. DATE <u>MAR 12 '62</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

Page 4

After death.

Page 4

After death.

Page 4

After death.

Page 4

After death.

Page 4

After death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03557

03550

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201 Williamsburg Drive		d. STREET ADDRESS 1 201 Williamsburg Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES First FRANCIS Middle VERMILLION Last		4. DATE OF DEATH 3 Month 18 Day 19 Year 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1917
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Pepco	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
3. FATHER'S NAME Charles T. Vermillion		14. MOTHER'S MAIDEN NAME Delia Dorsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 579-03-4441	
17. INFORMANT Alice L. Vermillion		Address 201 Williamsburg Dr, S.S., Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC VASCULAR DIS. DUE TO (c) PERIPHERAL VASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH IMMED. 10 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959 to MARCH , 19 62 , that (I) SA saw the deceased alive on 3-15 19 62 , and that death occurred at 6A M, from the causes and on the date stated above.			
22a. SIGNATURE Bernard A. Fitzgerald M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 3-18-62 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22d. ADDRESS 217 UNIV. BLVD. E. SIL. SP. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3-21-62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska ADDRESS 8434 Georgia Ave		25a. REC'D BY REGISTRAR DATE MAR 20 '62	
25b. REGISTRAR'S SIGNATURE Warner E. Pomphrey, Inc			

CORONER HAS BEEN NOTIFIED (AND APPROVED)

(M)

11/10/1914

03550

CERTIFICATE OF DEATH

1914

James Thomas

George Thomas

George Thomas

1914

1914

George Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03551

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 76 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Pennsylvania b. COUNTY Hustontown c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 75 x 3 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Madaline Vitti			4. DATE OF DEATH Month Day Year March 31, 1962				
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH January 20, 1921		9. AGE (In years last birthday) 41 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Jack Hann			14. MOTHER'S MAIDEN NAME UNK				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. UNK		17. INFORMANT Address Samuel J. Vitti Same As # 2			
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO (b) metastatic Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 3 mos.		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) January 5, 1962, to March 31, 1962			
21. I certify that xx (this hospital) attended the deceased from January 5, 1962, to March 31, 1962 , that xx (we) last saw the deceased alive on March 31, 1962 , and that death occurred at 1:05 AM from the causes and on the date stated above.							
22a. SIGNATURE William P. Baker M.D. 22c. PHYSICIAN'S NAME (Type) William P. Baker, LT MC USN			22b. DATE SIGNED U.S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National			
23d. LOCATION (City, town or county) (State) Arlington, Virginia		24. FUNERAL DIRECTOR'S SIGNATURE Pearson Funeral Home, 472 N. Wash. St., Falls					
25a. REC'D BY REGISTRAR DATE APR 3 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03551

Neconomy

Beanda (Pant)

U. S. Naval Hospital

With

Female

Homewite

Jack Hann

UNK

General J. V. V. V.

UNK

Microscopic Examination 3 mcs

W. L. Smith

William F. Baker, Jr. U.S. N.

U.S. Naval Hospital, Honolulu, T.H.

Person Federal Home, 415 N. Main, St. Louis

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03559 CERTIFICATE OF DEATH 03552

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blacksburg, d. STREET ADDRESS 207 Rose Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Harris Wardlaw		4. DATE OF DEATH March 7, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 December 1913
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 3 Days 5 Hours Min. 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. Store Manager		10b. KIND OF BUSINESS OR INDUSTRY Department Store	
11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph M. Wardlaw		14. MOTHER'S MAIDEN NAME Aurie Cox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 237-03-3195	
17. INFORMANT The Medical Record,		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aortic Insufficiency 411X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Aortic Stenosis (c) Rheumatic Heart Disease, Inactive	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (it (this hospital) attended the deceased from March 4, 1962 to March 7, 1962 , that (it) (we) last saw the deceased alive on March 7, 1962 , and that death occurred at 4:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W. B. Berry M.D.		22b. DATE SIGNED March 8, 1962	
22c. PHYSICIAN'S NAME (Type) W. B. Berry,		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit	23b. DATE THEREOF 3/8/1962	23c. NAME OF CEMETERY OR CREMATORY Silver Brook	23d. LOCATION (City, town or county) (State) Anderson County So. Carolina
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR MAR 14 '62	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

13252



... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03560

03553

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Damascus years c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 26920 Howard Chapel Dr.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 02 Damascus d. STREET ADDRESS 1 26920 Howard Chapel Dr.			
3. NAME OF DECEASED (Type or print) Marshall T. Watkins First Middle Last				4. DATE OF DEATH March 23 1962 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1886 75 yrs.	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (County & State, or foreign country) Damascus, Md.	
13. FATHER'S NAME Uriah Watkins				14. MOTHER'S MAIDEN NAME Margaret Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-44-7826		17. INFORMANT Mrs Mattie E. Watkins, Item 2 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/15 1963 to 3/23 1962 that (I) (we) last saw the deceased alive on 3/23 1962 and that death occurred at 7P.M. from the causes and on the date stated above.							
22a. SIGNATURE James P. Kerr				22b. DATE SIGNED 3/24/62		22c. PHYSICIAN'S NAME (Type) James P. Kerr	
22d. ADDRESS DAMASCUS, MD.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/26/62		23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		23d. LOCATION (City, town or county) (State) Clagettville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Clint L. Moleworth				25a. REC'D BY REGISTRAR MAR 27 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOPEFUL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1

03280

STATEMENT OF DEBIT

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

03280

1
FOR STATE
HEALTH DEPT.
M
X
I
0
15
2
VS. A15ME
SM 7/59

MAYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03554									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN lb 4 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9918 Markham St.					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Silver Spring d. STREET ADDRESS 9918 Markham St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ruth Gertrude Whittemore					4. DATE OF DEATH March 4 19 62				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1913		9. AGE (In years last birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Wash. Hosp. Center		11. BIRTHPLACE (State or foreign country) Washington County, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James R. Whitlock					14. MOTHER'S MAIDEN NAME Susie D. Taylor				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles H. Whitlock 2014 Drexel St., S.S., Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 3rd degree burns involving 100% of body IMMEDIATE CAUSE (a) 9/16.0 DUE TO sudden Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in bed which was completely burned							
20c. TIME OF INJURY 1:15 p.m. 4/4 1962		20d. INJURY OCCURRED While at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Silver Spring (County) Montg. Md. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4/4/ 62 DATE SIGNED 4/4/ 62 Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-62		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery			22d. LOCATION (City, town, or country) Arlington, Virginia (State)		
23. FUNERAL DIRECTOR Raymond A. Ziska Warner E. Pumphrey, Inc. Silver Spring, Md.					24a. REC'D BY REGISTRAR 4/4/ 62 DATE MAR 7 '62		24b. REGISTRAR'S SIGNATURE Arthur S. House		

THE STATE
HEALTH DEPT.

17

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Usual residence: _____

7. Cause of death: _____

8. Date of death: _____

9. Time of death: _____

10. Place of death: _____

11. Signature of Medical Examiner: _____

12. Signature of Coroner: _____

13. Signature of Registrar: _____

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03562
CERTIFICATE OF DEATH
03555

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 9 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3906 Spruett Court			d. STREET ADDRESS 1 3906 Spruett Court		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Roy R. Wilburn			4. DATE OF DEATH Month Day Year March 17, 1962 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1897		9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Wm. J. Wilburn			14. MOTHER'S MAIDEN NAME Annie Durst		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-8958		17. INFORMANT James H. Edwards-Item# 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1 & 2 a. IMMEDIATE CAUSE (e) DUE TO Greenomatosis b. Bronchogenic Carcinoma c. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) March 14, 1962 March 17, 1962					INTERVAL BETWEEN ONSET AND DEATH (2) June, 1961 June, 1961
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from March 14, 1962 to March 17, 1962, that (I) (me) last saw the deceased alive on March 14, 1962, and that death occurred at 9:00 P.M. from the causes and on the date stated above.					
22. SIGNATURE George A. Gray, Jr. M.D.			22a. PHYSICIAN'S NAME (Type) George A. Gray, Jr. M.D.		22b. ADDRESS 4740 Chevy Chase Dr., Chevy Chase, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/20/62		23c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE	
24. FUNERAL DIRECTOR'S SIGNATURE Don Newman, Grantsville, Md			25a. REC'D BY REGISTRAR DATE MAR 20 '62		
			25b. REGISTRAR'S SIGNATURE Arthur S. Hume		

M

I

MEDICAL CERTIFICATION

08555

CENTRAL CASE DE BEIN

3805

M

Don't know
Gammage
Gammage

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 copies to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03563

03556

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina b. COUNTY Statesville c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 70X-3 d. STREET ADDRESS 402 Hillcrest Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Helen Louise Wilson			4. DATE OF DEATH Month Day Year March 2 1962		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH December 10, 1922		9. AGE (In years last birthday) 39		10. IF UNDER 1 YEAR Months Days 39	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Not applicable		13. BIRTHPLACE (County & State, or foreign country) North Carolina	
14. FATHER'S NAME Bunk Sherrill		15. MOTHER'S MAIDEN NAME Lillian Cline		16. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		18. SOCIAL SECURITY NO. None		19. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension, Circulatory Failure 204-3 DUE TO (b) GRAM NEGATIVE SEPTICEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Acute LYMPHOBLASTIC LEUKEMIA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 2 hours 3 days 1 MONTH					
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 22b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.)					
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		23d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		24e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
25f. (City or town) February 28, 1962		26f. (County) March 2, 1962		27f. (State) 1962	
28. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 28, 1962 to March 2, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 2, 1962 , and that death occurred at 7:35 PM on the causes and on the date stated above.					
29a. SIGNATURE Marvin A. Kirshner M.D.			29b. DATE SIGNED 3-3-62		
30c. PHYSICIAN'S NAME (Type) Marvin A. Kirshner, M.D.			30d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		
31. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 3-3-62		32. DATE THEREOF 3-3-62		33. NAME OF CEMETERY OR CREMATORY Iredell Memorial Park, Statesville, No. Carolina	
34. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		35. ADDRESS Bethesda, Md.		36. REC'D BY REGISTRAR DATE MAR 7 '62	
37. REGISTRAR'S SIGNATURE Arthur S. Hume					

03253



only showing

Patentable

2 days

Patentable

100-1111111111

100-1111111111

Patentable

Patentable

Patentable

Patentable 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

Patentable

Patentable

Patentable

Patentable

Patentable

Patentable

The Clinical Center, Bethesda, Md.

The Clinical Center, Bethesda, Md.

None

None

February 10, 1952

1:30 PM

1:30 PM

1:30 PM

1:30 PM

The Clinical Center, Bethesda, Md.

The Clinical Center, Bethesda, Md.

The Clinical Center, Bethesda, Md.

Robert A. Humphrey, Bethesda, Md.

Robert A. Humphrey, Bethesda, Md.

Robert A. Humphrey, Bethesda, Md.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03557														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Va</u> b. COUNTY <u>Taywell</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Poolesville (uninc)</u> DCA					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Formding mill</u> 83X-3									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Willard Rd</u>					d. STREET ADDRESS									
3. NAME OF DECEASED (Type or print) First <u>Ealy</u> Middle <u>Homer</u> Last <u>Wingo</u>					4. DATE OF DEATH Month <u>Mar</u> Day <u>10</u> Year <u>1962</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov-3-1896</u>		9. AGE (In years last birthday) <u>65</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME <u>Thomas Wingo</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>223-40-1496</u>					17. INFORMANT <u>Etienne Wingo - Poolesville md - R-2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal hemorrhage</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Crushed chest</u> (c)										sudden				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
<u>Fracture of left Flngx</u>														
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in car involved in accident</u>										
20c. TIME OF INJURY Month, Day, Year <u>7/15</u> p.m. <u>3-10</u> 19 <u>62</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Poolesville mnty md</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-10-62</u>						
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>3-10-62</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/14/62</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Phillipsie</u>						
23. FUNERAL DIRECTOR <u>William B. Hilton, Barnesville, Md</u>				22d. LOCATION (City, town, or country) (State) <u>Waymire, Virginia</u>				24e. REC'D BY REGISTRAR <u>15 '62</u>						
				24b. REGISTRAR'S SIGNATURE <u>W. S. Frank</u>										

MEDICAL CERTIFICATION

08282

17

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "the" are visible.]

TO 1. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
03565					03558					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Montgomery					a. STATE District of Columbia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)					b. COUNTY Washington D.C.					
c. LENGTH OF STAY IN 1b 3 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital					d. STREET ADDRESS 615 Alabama Ave S.E. Apt#1					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last Paul John WISNIEWSKI					Month Day Year March 26 1962					
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 March 1962		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 3		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ronald R. Wisniewski					14. MOTHER'S MAIDEN NAME Nancy Ann Sugyik					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. -----		17. INFORMANT Address -----			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Post op status 2 days closure of Omphalocele DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----								INTERVAL BETWEEN ONSET AND DEATH -----		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1B.) -----					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 March, 19 62 to 26 March, 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 26 March, 19 62 ..., and that death occurred at 1:12 AM , the causes and on the date stated above.										
22e. SIGNATURE Lawrence G. Thorne					22f. PHYSICIAN'S NAME (Type) L.G. Thorne, LT MC USN		22b. DATE SIGNED 26 March 1962		22c. ADDRESS U.S. Naval Hospital Bethesda Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-27-62		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler					24a. ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR MAR 28 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Fenn	

2.001982

(M)

03882

03882

(Continued)

Postmaster (Name)

U.S. Naval Hospital

John

Paul

WISCONSIN

March

23 March 1962

Gene

Montgomery, Maryland

Henry and Mary

Marion R. Wisniewski

Postmaster

Post of return 2 days closure of telephone

23 March 1962 10:10 AM

23 March 1962

[Handwritten signature]

J.C. Thomas, Jr. MD USN

U.S. Naval Hospital Bethesda, Md.

Encl

Washington, D.C.

Montgomery, Md.

Washington, Virginia

Typed-Name of Recipient Name, Full N. Montgomery, Md. 21201

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03556 CERTIFICATE OF DEATH 03559											
Items 8&9 Film 311 4/12/62 iwk											
1. PLACE OF DEATH a. COUNTY MONTGOMERY				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 15 MINS.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE PENNSYLVANIA				b. COUNTY DELAWARE			
3. NAME OF DECEASED (Type or print) HENRIETTA				First Middle Last MARIE WOLF				4. DATE OF DEATH 3-20-62			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-27-1892		9. AGE (In years last birthday) 69 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED R. N.				10b. KIND OF BUSINESS OR INDUSTRY ENGLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME UNKNOWN (PAYTON)				14. MOTHER'S MAIDEN NAME (UNKNOWN)				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT HOSPITAL RECORDS				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4x10x M ESENTERIC THROMBOSIS DUE TO (b) MURAL THROMBOSIS, LEFT AURICLE DUE TO (c) MITRAL STENOSIS								INTERVAL BETWEEN ONSET AND DEATH 24 HRS 1 MONTH ? 20 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CEREBRAL THROMBOSIS, LEFT HEMISPHERE								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) CLARKSVILLE, MARYLAND		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB 11 1962 to MAR 20 1962 that (I) saw the deceased alive on MAR 20 1962 and that death occurred at 7:30A M, from the causes and on the date stated above.											
22a. SIGNATURE Charles S. Whitaker, M.D.				22b. DATE 3-20-62				22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-24-62		23c. NAME OF CEMETERY OR CREMATORY Westminister		23d. LOCATION (City, town or county) (State) Philadelphia, Pa			
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				25a. REC'D BY REGISTRAR DATE MAR 22 '62				25b. REGISTRAR'S SIGNATURE Arthur J. Hume			



03553

3508

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

BRUNSWICK

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13 & 14 File G308

03560

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>8 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8400 Manchester Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>23 Silver Spring</u> d. STREET ADDRESS <u>18600 Manchester Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen Hawthorne Zimmerman</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 15, 1899</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>62</u> Mins. <u>62</u>		4. DATE OF DEATH <u>Mar 5 1962</u> Month Day Year 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> 11. BIRTHPLACE (State or foreign country) <u>N. J.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(unknown)</u> 14. MOTHER'S MARRIEN NAME <u>(unknown)</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>148-07-2731</u> 17. INFORMANT <u>Marcel Zimmerman</u> Address <u>Stem 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> (b) <u>Arteriosclerosis</u> (c) <u>gms</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Frank J. Broschert</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-5-62</u> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>3-7-62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> 22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>		23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u> Address <u>434 Georgia Ave.</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Maryland</u> 24a. REC'D BY REGISTRAR <u>MAR 7 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

TO SPIRITUAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO SPIRITUAL DIRECTOR: The law requires that the death certificate be extended on 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 Film G311 1/21/62 ink

03561

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Minnesota</u> b. COUNTY <u>AUSTIN</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>919 4th. Avenue N.E.</u> <u>4357 11 ALTON PL NW</u>	
3. NAME OF DECEASED (Type or print) <u>FRANCES K ZIMPRICH</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>11</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/88</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u>	11. IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNEMPLOYED</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. M. Straus</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Barth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-56-1991</u>	
17. INFORMANT <u>MELBA Z. TEMPLEMAN</u>		Address <u>4357 ALTON PL NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thromboses</u> <u>332X</u> DUE TO (b) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c) <u>Diabetes mellitus</u> (e), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/2/62</u> , 19 <u>62</u> , to <u>3/11/62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/10/62</u> , 19 <u>62</u> , and that death occurred at <u>4:20 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Donald Nelson</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>DONALD NELSON MD</u>		22d. ADDRESS <u>10620-GA. AVE. SIL. SP. MD.</u>	
23a. (BURIAL) CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>MARCH 16, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CATHOLIC CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>AUSTIN, MINNESOTA</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hannon - 4748 - West. Ave.</u>		25a. REC'D BY REGISTRAR <u>MAR 19 '62</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hannon</u>	

03281

03281

M